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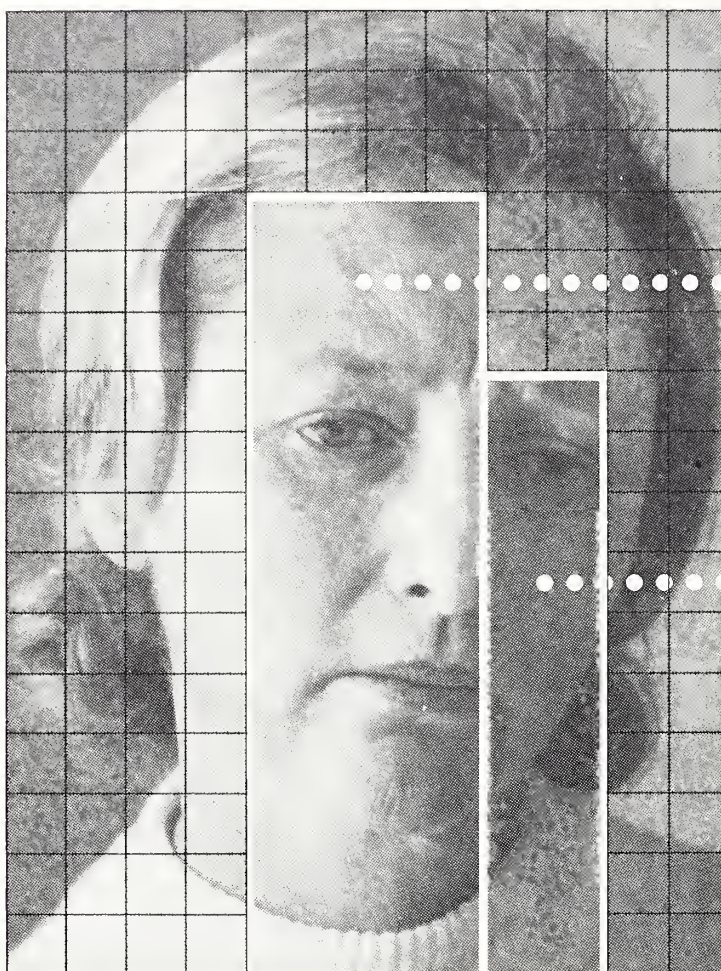
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ON STUFFING CROW

I hope that my colleagues in the upper echelons of the AMA didn't impair their digestive tracts during the recent holidays. They will have a lot of crow to eat and it might prove to be quite indigestible, especially to the ones who uttered and wrote those imperious admonitions about raising fees for our professional services. They are the ones who urged us to work more efficiently, to operate more economically, to make some sacrifices and to lower our standards of living. With wagging fingers and clucking tongues, they warned us that Big Brother was watching and would consider the raising of fees sufficient evidence of felonious greed and criminal selfishness to justify locking us in chains.

All the while these policy-making leaders, these spokesmen of our nation's physicians were letting the AMA spend itself into bankruptcy. More accurately, it seems they were pursuing bankruptcy with shocking candor. At a time when prime interest rates were usurious, they were down at the bank, negotiating a multimillion dollar loan. Then, with an almost-contemptuous air of self-righteousness, they had the temerity to demand an increase in our dues and a mandatory assessment in order to pay off the note and preserve our solvency.

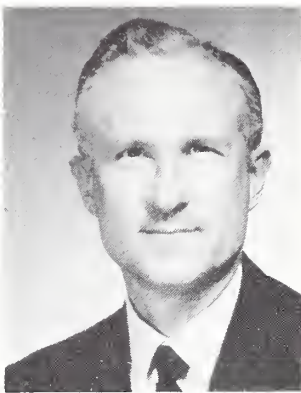
Costs have risen sharply they explained, and we must reckon with inflation. Also, they have expanded membership services and benefits in

such ways as publishing an out-sized, artsy periodical wherein non-practicing experts in health care delivery can belabor us with their counsel. And by attacking groups of physicians (AAPS) who are critical of many official AMA positions, deriding the size of their organizations and the small towns in which its members practice. And by railroading debate at AMA meetings. And by hiring the editors and reporters and staff assistants skilled enough to provide these services.

Clearly, it is terribly expensive to alienate the entire membership of a large organization. But they have succeeded. And at least they have been consistent; their judgment has been unvaryingly bad. They have embraced Medicaid, Medicare, PSRO and The Bureaucracy. They have endorsed fee schedules, medical merchandising and the piracy of foreign physicians. They have been derogatory of their critics, suspicious of their friends and inept in their politics. How perfectly logical that they now demand gratuities from those who have been injured.

Nevertheless, I am going to pay to continue my membership in the AMA. Certainly, I could never again support mandatory membership, but to leave the AMA now would be to abandon a patient at the crisis of his illness. So I am sending in my sixty dollars. I hope part of it, at least, pays for the crow. And I will gladly help stuff it. . .down the deserving throats. MRJ

There can be little doubt that peer review is both justified and logical — the Oklahoma State Medical Association has been carrying on peer review for professional services for approximately nine years. In fiscal 1972 Americans spent 7.6% of the gross national product, or \$83.4 billion, on personal health care — double the amount spent in 1965, much of which (52%) was in keeping up with inflation. In fiscal 1973 the figure approached \$100 billion. This care was delivered in 7,000 hospitals, 29,000 nursing homes and innumerable medical offices by 2½ million personnel, including almost 400,000 physicians. This vast industry is the largest and most complex in the United States. Reasonable cost controls and assurance of quality are not unreasonable, but the PSRO law has included sweeping controls that have not been imposed upon any profession in the United States. No such mechanism for monitoring health care has ever been tried in any existing health care delivery system anywhere. While there is thin allusion to quality, the main thrust is at cost control. Administration costs alone are anticipated to be some \$350 million annually and possibly more. Any program involving this much money and this much power will attract supporters, not only from without the profession, but — alas — also from within. It is certain to add to the cost of medical care. Worse than that are other implications in the bill, such as "Professional Standards Review Organizations will have the authority to approve, in advance, the medical necessity of elective



admissions to institutions, as well as extended or costly services."

The entire proposal — now actual law — was accepted and promoted by our national organization; true, the organization requested numerous modifications, but the modifications have not been forthcoming. The circumspect procedure would have been to obtain the modifications before giving support.

On a happier note, I am delighted to report that our association's efforts to assist the Health Sciences Center have been finally productive. In addition to putting on our program in 15 different areas of the state, your Medical Liaison Committee members and your three executive directors have had innumerable meetings with a large number of state legislators, civic leaders, faculty members, University Regents, Higher Regents, President Sharp and his staff at the University in Norman, national legislators and Governor Boren. Fine cooperation has been exhibited on all sides and I believe the immediate future will reveal a greater support for our medical school and University Hospital than has been experienced in a very long time. I am indeed proud of the contributions of both time and money that you have made in this effort. It proves once again that Oklahoma has a fine medical association. I am honored to be a member of it. Few associations have the firmness of purpose, devotion to duty, loyalty to cause and unity of action as does ours.

Before closing, I should like to call your attention to the hard work and fine organization efficiency being exhibited by Chairman Marion Wagon and his committee to develop an outstanding program for Summit '75 in April at Lincoln Plaza. Please make the necessary office adjustments and plans at an early date to assure attendance.

J. L. Richardson, M.D.

Civilian Vascular Injuries: A Clinical Review

THOMAS A. MARBERRY
JAMES M. HARTSUCK, MD
G. RAINEY WILLIAMS, MD

Since the volume of civilian vascular injuries has increased over the last decade, aggressive surgical management with early angiography, exploration and operative repair appears to be justified.

The management of patients with vascular injuries has become more clearly defined and the benefits of precise surgical reconstruction of the vascular system have become apparent as the result of the extensive clinical experience gained from wartime vascular trauma^{9, 12}. Vascular injuries among civilians have been less well studied but the clinical problem is increasing with the present higher incidence of penetrating trauma. As a result of the increased volume of civilian vascular injuries the need for clear policies concerning early exploration, angiography, and prompt, precise vascular repair has become evident. Many civilian institutions have adopted policies of early exploration when vascular injury is considered likely^{2, 5, 10, 13}. In an effort to evaluate these policies a clinical

review of patients from the University of Oklahoma Health Sciences Center who were operated upon for possible traumatic vascular injury from the period 1963 through 1972 was undertaken. An effort was made to correlate the clinical signs with the actual vascular injury and to evaluate the results of a liberal policy of exploration for penetrating wounds near major vessels.

REVIEW OF CLINICAL MATERIAL

The records of all patients at the University of Oklahoma Health Sciences Center who underwent surgical exploration for possible vascular trauma were reviewed for the past ten years. The patient population included the adjacent metropolitan area and referrals from the entire state. Individual cases were considered "positive" if vascular injury was demonstrated through surgery and "negative" if no vascular trauma was found. In both categories the presence of hematomas, absent distal pulses, and associated injuries including trauma to nerves, tendons, and bone was recorded. The method of surgical reconstruction as well as the value of angiography both preoperatively and intraoperatively were evaluated. Patients with only intra-abdominal vascular injury were excluded since nearly all patients with penetrating abdominal trauma were routinely explored. A significant number of vascular injuries due to diagnostic or therapeutic maneuvers were also excluded.

The incidence of recognized trauma to the

From the Department of Surgery, University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma.

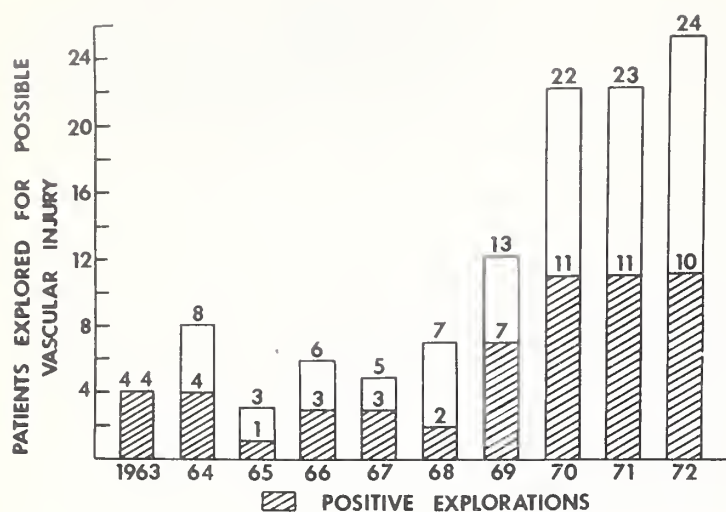


Table 1

vascular system has increased significantly over the past decade and dramatically in the past three years as depicted in Table 1. The total number of patients undergoing surgery each year in the Oklahoma Health Sciences Center has remained relatively constant during this study. It is noteworthy that the percentages of negative and positive explorations have remained relatively constant during this ten-year period.

Analysis of the anatomical site of injury reveals that the upper extremity is the most commonly injured region followed by injuries to

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A 1950 graduate of Northwestern University Medical School, G. Rainey Williams, MD, has been certified by the American Boards of Surgery and Thoracic Surgery. He is Professor and Chairman of the Department of Surgery at the University of Oklahoma College of Medicine. Doctor Williams is Governor of the American College of Surgeons, Treasurer of the Southern Surgical Association, a member of the American Surgical Association, the American Association for Thoracic Surgery and the Halsted Society.

the neck (Table 2). The fraction of positive explorations was relatively constant for the various anatomical sites. Negative explorations were also investigated in an effort to evaluate the incidence of "significant" associated injuries which made the exploration a valuable experience for the patient. "Significant" associated injuries were defined as those injuries that were physiologically significant and surgically correctable. Total associated injuries included significant injuries plus those that were not surgically correctable, eg, fractures treated by splinting or casting and nerve contusion which resulted in impaired function.

The negative explorations were also evaluated in an effort to define clinical characteristics of patients with positive and negative exploration of the various anatomical sites. Neck injuries were associated with the most frequent negative explorations (57%). These neck injuries were commonly accompanied by hematomas and clinical absence of distal pulsation even in the absence of significant vascular injury (Table 3). It is of interest that 31% of such negative explorations had surgically treatable injuries including two instances of unsuspected laceration of the esophagus or posterior pharynx, a spinal cord injury which required posterior laminectomy, and two instances of parotid gland injury managed with drainage. The incidence of significant associated injuries is higher when vascular disease is demonstrated by exploration; 45%, when compared to the 22% incidence of significant injuries associated with negative vascular exploration. Significant associated injuries were found in five of six patients with popliteal area arterial trauma. Four of these six patients had major venous injury, four had significant nerve damage and two had associated fractures either of the proximal tibia or fibula. The analogous upper extremity brachial artery injuries were also found to have a high incidence of significant associated injuries, 70%.

Hematoma was evident with equal frequency in patients with and without vascular injury. However, the absence of a palpable distal pulsation was documented in 57% of patients found to have significant vascular trauma and only 15% of those with negative exploration ($p < 0.0001$ that these are the same in a chi squared test). Seven patients underwent preoperative angiography and later had positive explorations. The preoperative angiography was diagnostic of arterial trauma in each of these instances.

SITE OF INJURY AND ASSOCIATED INJURY

Vessel	Total Exploration	Total Significant Associated Injuries	Positive Exploration	Total Associated Injuries	Significant Associated Injuries	Negative Exploration	Total Associated Injuries	Significant Associated Injuries
Brachial Artery	20	8	10	8	7	10	3	1
Radial Artery								
Ulnar Artery	19	10	10	9	7	9	6	3
Carotid Artery	21	5	5	0	0	16	6	5
Jugular Vein	7	1	7	2	1	0	0	0
Femoral Artery	20	5	10	3	3	10	2	2
Popliteal & Tibial Arteries	12	5	6	5	5	6	0	0
Thoracic	12	4	5	2	2	7	2	2
Iliac Artery	2	0	1	0	0	1	0	0
Iliac Vein	2	1	2	1	0	0	0	0
TOTALS	115	39 (33.8%)	56(48%)	30(53%)	25(45%)	59(59%)	19(32%)	13(22%)

TABLE 2

Intraoperative arteriography was also of value. For example, in one instance, routine angiography after femoral artery reconstruction revealed a clot at the popliteal trifurcation. This occlusion was unsuspected clinically and the demonstration by angiography permitted simple extraction at the time of operation (Fig 1, 2.)

The majority of patients with vascular injuries were managed by resection and reanastomosis (Table 5). It was possible to reconstruct all of the brachial artery injuries and to establish pulsatile flow distally. Six of the ten radial-ulnar injuries involved the ulnar artery and five of these were ligated without ill effect. Only one of the four radial artery injuries were managed by ligation. In the five carotid injuries, vascular reconstruction was possible and adequate flow established. One internal jugular vein was managed by suture repair and the other ligated. Two instances of ligation at the iliac level were performed, one for injury of the iliac vein and the other for injury to the internal

iliac artery. Only four cases of the 56 positive explorations developed postoperative complications and required amputation of the involved limbs. Analysis of these patients includes one patient admitted 2½ weeks after a gunshot wound of the popliteal fossa, two patients with gunshot wounds to the brachial artery managed

NEGATIVE EXPLORATIONS: CLINICAL FINDINGS

Vessel	Explorations	Hematoma	% Absent Distal Pulse	%	
Brachial	10	4	40%	2	20%
Radial-Ulnar	9	2	22%	0	0%
Carotid					
Jugular	16	10	62%	3	19%
Femoral	10	5	50%	2	20%
Popliteal-Tibial	6	6	100%	1	17%
Thoracic	7	3	43%	0	0%
Iliacs	1	0	0%	1	100%
TOTALS	59	30	50%	9	15.2%

TABLE 3



Fig 1: Routine operative arteriogram demonstrated an unsuspected obstruction of the distal popliteal artery.



Fig 2: Completion arteriogram after Fogarty extraction of popliteal thrombus.

by tourniquet with delayed repair which resulted in progressive ischemia despite successful vascular reconstruction, and a fourth patient admitted two days following popliteal artery injury with established gangrene.

Four deaths occurred (3.5%), all in the positive exploration group. One patient died in the operating room of hypovolemic cardiac arrest secondary to transection of the pulmonary artery before control of the injured vessel could be achieved. Two other deaths occurred in the postoperative period and were attributed to postoperative pulmonary insufficiency. The fourth death occurred in the operative period and was due to ventricular fibrillation secondary to hypovolemia as a result of uncontrolled intra-abdominal bleeding.

DISCUSSION

It is obvious from our clinical review and from other published studies^{3, 4, 11} that the incidence

POSITIVE EXPLORATIONS:
CLINICAL FINDINGS

	# Positive Exploration	Hematoma	%	Absent Distal Pulse	%	Pre-Op Arteriogram
Brachial	10	1	10%	7	70%	0
Radial Ulnar	10	1	10%	5	50%	0
Carotid Artery	5	4	80%	3	60%	2
Jugular Vein	7	4	57%	1	14%	0
Femoral	10	7	70%	8	80%	3
Popliteal-Tibial	6	4	67%	6	100%	2
Thoracic	5	3	60%	0	0%	0
Iliac Artery	1	1	100%	1	100%	0
Iliac Vein	2	2	100%	1	50%	0
TOTALS	56	27	48.2%	32	57%	7

TABLE 4

of vascular trauma among civilians has increased in the past decade. Since delay in surgical intervention has been responsible for loss of limbs as well as increased morbidity, we have adopted a liberal policy of exploration of penetrating injuries adjacent to major vascular structures as advocated by Patman, Triman, Pearch, Moore^{7, 9, 10, 13}. Nevertheless, this liberal policy for exploration has been accompanied by a significant number of negative explorations. Specifically, this has been a common experience with penetrating trauma of the neck when the policy of exploration of wounds which penetrated the platysma was adopted⁶.

Analysis of our patients who underwent negative explorations reveals a very low complication rate without significant morbidity in 59 consecutive cases. The high incidence of hematoma (50%), and low but significant incidence of clinically absent distal pulses, (15%), are noteworthy features. Associated injuries

POSITIVE EXPLORATION: TREATMENT

Vessel	# Positive Explorations	Ligation	Reanas-tomosis	Suture Repair	Venous Graft	Operation Arteriogram
Brachial	10	0	6	1	3	2
Radial-Ulnar	10	6	4	0	0	0
Carotid Artery	5	0	3	2	0	0
Jugular Vein	7	6	0	1	0	0
Femoral	10	1	4	3	2	2
Popliteal-Tibial	6	1	1	0	4	0
Thoracic	5	2	0	2	0	1
Iliac Artery	1	1	0	0	0	0
Iliac Vein	2	1	0	1	0	0
TOTALS	56	18	18	10	9	5

TABLE 5

were found in 19 of these 59 negative explorations and 13 of these associated injuries needed surgical correction. Thus, it appears that the benefits of the liberal policy of exploration far outweigh the morbidity.

The management of patients with significant vascular injuries was extremely successful. Vascular patency was achieved in all cases in which restoration of flow was attempted. Only four patients required amputation and in each instance delay in vascular reconstruction was a major factor.

Operative arteriography was not employed routinely but in selected instances and was extremely valuable in documenting technical errors or distal intravascular obstruction. Failure of vascular reconstruction appeared related to delay in reconstruction in patients with extensive injury^{1, 2}.

We conclude that the liberal policy of early exploration for penetrating wounds adjacent to major blood vessels should be continued. A high rate of negative exploratory procedures appears justified when one considers the minimal morbidity and the significant number of associated injuries thus discovered. Mufti and his associates⁸ have demonstrated both clinically and experimentally that arteriography may be unreliable in detecting early arterial injury or later complications; yet, pre-, intra-, and post-operative angiography are worthwhile procedures and as advocated by Moore, Perry and others^{7, 11} their indications should be liberalized.

SUMMARY

A clinical review of 115 patients who underwent surgical exploration for possible vascular trauma in the past ten years indicates that the incidence of civilian vascular injuries is increasing. Aggressive surgical management with early angiography, exploration, and operative repair appears to be justified. Although negative explorations are not uncommon, the low morbidity and significant incidence of associated, correctable injuries found, support this policy. Also, delay in vascular reconstruction is a major factor contributing to limb loss. The correlation of vessel injury with anatomic site, hematoma, absent pulse, and associated injuries is presented. □

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Towards Control of Breast Cancer In Oklahoma

ARTHUR F. HOGE, MD
G. BENNETT HUMPHREY, MD, PhD

Breast cancer is becoming a controllable disease. Basic and clinical research are leading to patient management plans capable of producing 80 to 85 percent response rates. The Oklahoma Medical Research Foundation has established a statewide demonstration network to disseminate information to the hospitals of Oklahoma.

When one speaks of cancer control many people do not quite understand the meaning. Is it an enigmatic expression? Is it a real possibility or merely a challenge? If real progress in the control of cancer is to occur it almost certainly would occur in one or more of five specific areas: prevention, early diagnosis, primary therapy, rehabilitation, or treatment of advanced disease.

Research in breast cancer has made some rather impressive advances in the past decade. A virus which may have an etiologic role has been isolated.¹⁻³ The genetic material of this virus has been identified within the DNA of some tumor cells⁴⁻⁶ and an immunologic specificity can be demonstrated with both human breast cancer and a mouse mammary

cancer.^{3, 7} This does not imply a common causative role for all breast cancers but certainly points toward a viral etiology of many. Further studies in etiologic and immunologic fields would indicate possible methods of prevention within the next decade.

Early diagnosis has been enhanced by the usage of mammography, thermography, and Xeroradiography (a more refined type of mammography). Screening centers have been established across the country and have utilized visual and palpatory breast examinations together with the more highly sophisticated methods mentioned above. These centers have demonstrated a capability of diagnosing preclinical lesions with a high degree of success, having a false-positive rate of only 15% and a false-negative rate of 10%-15%.⁸

When one considers the logistics of screening large populations, limitations become evident. Doctor JoAnn Haberman's screening center at the Health Sciences Center has been strained in managing some 10,000 patients yearly. Even considering the availability of mammography and Xeroradiography in other institutions throughout the state, mass screening of over 1.5 million people is still not practical.

Breast self-examination (BSE) has been advocated by the American Cancer Society for more than 15 years. The vast majority of breast lumps should be palpable when they are 0.5-2.0 cm in diameter if the technique is properly employed. Patients who have a lesion less than 2.0 cm in diameter and without skin, fascial, or grossly involved lymph nodes have a 95% chance of having a five-year disease-free survi-

Supported by National Cancer Institute Contract #N01-CN-45137 and, Cancer Planning Program Development, Health, Education and Welfare, P01 C013749 SRC.

val and a 90% chance of achieving a ten-year disease-free survival.

End results of primary therapy in breast cancer have changed very little in the past 70 years since Halsted described his procedure for radical mastectomy. Lesser operations performed prior to that time by other well-known surgeons were followed by recurrences of a very high rate in the neighborhood of 60%-80% as compared to a 45%-50% recurrence rate following standard radical mastectomy. National statistics indicate a slight increase in the incidence of breast cancer in the past 20 years with a rather constant death rate. This indicates a slight improvement in the relative survival rate but is most likely related to earlier diagnosis. Radical mastectomy, as such, is less than optimal therapy in patients who have nodal metastases, as 67% of these patients will demonstrate recurrent disease within five years and only 45% will survive more than five years.¹⁰⁻¹² Extending the mastectomy field to include supraclavicular and internal mammary nodal areas either by surgical^{11, 13, 14} or adjuvant radiation therapy^{11, 15-17} has not increased the survival rate. We are now witnessing serious challenges to this established and acceptable method of therapy. Crile,¹⁸ McWhirter,¹⁹ Roberts,²⁰ and others have proposed lesser procedures and a great debate has ensued. The NSABP clinical trials²¹ have not shown any significant difference in survival or development of metastases when comparing radical mastectomy vs simple mastectomy plus radiation therapy or standard radical mastectomy as

compared to standard radical mastectomy plus radiation therapy.

Fisher's National Surgical Adjuvant Breast Project has two-year results of a randomized prospective clinical trial to determine the relative merits of Halsted radical mastectomy vs simple mastectomy with or without radiation therapy. The two-year results reveal essentially no difference in recurrences or the development of metastatic disease in the patients of any of these three limbs. Another protocol randomizing patients at high-risk for recurrent breast cancer to mastectomy plus or minus phenylalanine mustard has produced statistically significant differences in the recurrence rates favoring those patients who have had adjuvant systemic chemotherapy.²² Only one of thirty pre-menopausal women treated with chemotherapy has had a recurrence within two years whereas 11 of 37 have had recurrences after surgery alone.

Biological studies of breast cancer have been most rewarding and probably will lead to rational changes in our approach to therapy, both at the time of initial diagnosis and at the time of first or secondary recurrence.

There are numerous types of breast cancer, many of which have a considerably different prognosis than others.²³ Intraductal papillary carcinomas behave considerably different from infiltrating ductal carcinomas and can be controlled by more limited procedures. Lobular carcinoma *in-situ* tumors have a relatively benign course and can be managed more conservatively than their more malignant counterparts. The same can be said of localized mucinous carcinomas or medullary carcinomas.

The aggressiveness of the tumor can also be modified by the host resistance and immunologic mechanisms. Foote and Stewart²⁴ first suggested the possible immunologic significance of the presence of lymphocytes in medullary carcinoma in 1946. Tumor specific antigens of breast cancer have been identified on the cell membrane,²⁵ within the cytoplasm,²⁶ and intranuclear.^{27, 28} These antigens are capable of inciting both humoral and cell-mediated responses with the production of auto-antibodies and sensitized lymphocytes which are capable of destroying tumor cells *in vitro*.^{29, 30} While antibody studies are effective means of demonstrating immunologic reactions and tumor-host relationships, Cytotoxic antibodies have not been demonstrated in breast cancer. The tumoricidal immunologic control mechanisms are mediated through the

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thymic oriented group of lymphocytes or T-cells.³⁰

Hudson³¹ has demonstrated a decreased titer of tumor specific antibodies in patients with far advanced and widespread tumor. We do not feel that this is in itself a manifestation of immunologic failure on the part of the host but is most likely an absorption phenomenon. Tumor cells may act as a large sponge and acquire a coating of antibody onto the cell membranes. This can effectively hide the antigens from the circulating T-cells. Tumors are capable of emitting large quantities of soluble antigens with resultant production of antigen-antibody complexes.

Competence of the cell-mediated immune system is paramount in considering therapeutic regimens in patient management programs, including surgical therapy, chemotherapy, and endocrine therapy.³³⁻³⁶

Studies of non-hormonal chemotherapeutic agents in the control of breast cancer have shown tremendous strides over the past 20 years, with the greatest improvement occurring in the past five years. Many chemotherapeutic compounds have been utilized successfully as individual agents.³⁷ These include the alkylating agents such as nitrogen mustard, cyclophosphamide, phenylalanine mustard, which can induce remissions in 25%-30% of patients. Antimetabolites including methotrexate and 5-FU have been effective in 25%-28% of patients and vinca alkaloids can be utilized with a response rate of 20%. Greenspan³⁸ in 1966, utilized the combination of chemotherapy including thiotepa and methotrexate with a response rate of 60%. Widespread acceptance of combination chemotherapy developed after Cooper³⁹ reported his five-drug regimen in 1969. He originally reported a 90% response rate but many studies have since been completed and indicate a true response rate of 55%. Hoogstraten's Southwest Oncology Group study⁴⁰ has been quite noteworthy. This group encompassed 200 patients and compared different dosage schedules utilizing the five-drug Cooper regimen to a new agent, adriamycin. The continuous dosage treatment plan was superior in patients below the age of 55 years while an intermittent schedule appeared to be more effective in older patients. This presumably could be related to estrogen stimulation and the proportion of cells in growth proliferative

phases of the cell cycle. The median duration of remission has been nine months in the continuous schedule and 13 months in the intermittent schedule. Adriamycin was shown to have a remarkable capacity to induce remissions as a single agent. The total remission induction rate was 40%. The drawback is a cumulative dose limitation because of cardiac toxicity and the relatively short median duration of remission which is only 4.5 months.

While oophorectomy has been widely accepted and used as the choice of therapy at first recurrence since 1896, the addition of adrenalectomy or hypophysectomy has been less favorably received. This was because of the early high morbidity and mortality associated with the more extended procedures. This mortality has now been reduced to a very acceptable rate of less than 2%, and the combination of oophorectomy and adrenalectomy or hypophysectomy can be expected to produce remissions in 44% of the patients.⁴¹ The most appealing thing about endocrine ablation is the median duration of remissions which is 23 months for the extended endocrine ablation as compared to the 4-9 months median duration of remissions in patients treated with chemotherapy.⁴¹ A study of the adrenalectomy/oophorectomy patients at the Oklahoma Health Sciences Center⁴² revealed a strong correlation of response with competence of the cell-mediated immune system. Patients who had or were able to develop a good immune competence after treatment responded dramatically to this therapeutic regimen, whereas patients who had a poor immune competence generally failed to respond to treatment. Adrenalectomy and oophorectomy responses favor those tumors which have a long disease-free interval, have relatively well-differentiated cell types, have estrogen binding receptors, and a good immune competence.

Chemotherapy is more favorable in more aggressive and rapidly growing tumors with a short disease-free-interval; the presence of an estrogen-binding receptor is not important.

We felt that combining chemotherapy with endocrine ablation might encompass an admixture of tumors; however, the chemotherapy is strongly immunosuppressive. If chemotherapy is stopped, the immune competence quickly returns and frequently to a heightened level.^{43, 44} We have now been utilizing extended endocrine ablation plus *limited term* combination chemotherapy for 15 months and have observed

favorable objective responses in 21 of 25 patients, a response rate of 83%. We are currently studying methods of maintaining and extending the duration of these remissions.

The American Cancer Society has recognized the large number of people who are surviving longer periods of time after breast cancer is diagnosed. They have embarked upon an extensive program for rehabilitation of these people in an effort to return them to normal life-style patterns. This program involves all aspects of sociological, psychological, and physical rehabilitation efforts and is administered by carefully selected and trained individuals most of whom have experienced a mastectomy.

With this brief review we can readily see that research in breast cancer is beginning to produce rewards. Improvement in research results is being reported regularly and it is imperative that we set up mechanisms whereby this information can be readily disseminated to primary care institutions.

The Oklahoma Medical Research Foundation has been funded by the National Cancer Institute for the operation of a Network Demonstration Project. The American Cancer Society has been very instrumental in the development and assistance in operation of the program. Twenty-three representative hospitals have been selected across the state where total management programs can be initiated. While it is true that some hospitals may not have the facilities to embark upon some sophisticated programs, they have access to these through their established referring patterns. The program has two major committees as the backbone of the operation. The first of these is a Developmental Therapy Committee coordinated by Doctor Michael T. Shaw, a hematologist-oncologist with the Oklahoma Medical Research Foundation and the Department of Medicine, University of Oklahoma Health Sciences Center. It is composed of representatives from the fields of pathology, radiology, and nuclear medicine; surgery, radiotherapy, and medical oncology. Many of these investigators are engaged in private practice and have given valuable assistance to the program. This committee investigates both clinical and basic research protocols and monitors those in other institutions in cooperative group studies. When research protocols have proven to be significantly better than others now in vogue, the protocol is re-written into a patient management plan and

submitted through the NCI to a large team of consultants.

The Consultants Committee is coordinated by Joseph M. Parker, MD, surgeon and former President of the American Cancer Society, Oklahoma Division. It is composed largely of physicians in private practice representing surgery, radiation therapy, medical oncology, nuclear medicine and pathology. This group meets quarterly to evaluate all protocols recommended by the Developmental Therapy Committee and to review all clinical activities of the program. Representatives of this committee are to meet with hospital tumor boards at least once monthly for dissemination of current knowledge and to act as a multi-disciplinary team of consultants. In most instances one or more members of the hospital staff will be a part of the consulting team. This team of consultants is also readily available for instant consultation over a tele-communication network. These conferences can be arranged by calling the Network Project office at the Oklahoma Medical Research Foundation, area code 405-235-8331, extension 254.

Other committees which have been appointed and are active include Professional and Lay Education Committees, a Nursing Committee, and Program Evaluation Committee.

The Program has four District Representatives each of whom is a well-educated and specially trained oncologic nurse. These nurses meet with tumor boards at each of the hospitals and are working through the hospital administration and nursing staff to train oncologic nurses in each hospital. Oncologic nurses have the capability of administering cancer chemotherapeutic agents and will have a full knowledge of rehabilitation programs, patient management plans, and experimental protocols including currently used experimental drugs.

While the ultimate mortality of breast cancer may require preventive measures not yet available, we feel that we can initiate long-range patient management programs which can provide a productive longevity of survival with normal life-style patterns. □

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2:45 to 3:45 P.M.	Pulmonary Problem Case Conference	C007 Everett Hospital
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Laboratory Practices In Mycobacteriology: Results Of A Survey Of Oklahoma Laboratories

DIXIE E. SNIDER, JR., MD
R. LEROY CARPENTER, MD, MPH

The results of a survey of Oklahoma laboratories indicate that some laboratories need to change their procedures and policies regarding tuberculosis bacteriology work.

I. INTRODUCTION

The isolation and identification of *Mycobacterium tuberculosis* in tissues and body fluids require special staining techniques, specific cultural conditions, and a niacin test. Even more specialized and sophisticated techniques are required to identify the various species of "atypical" mycobacteria.^{1, 2} Consequently, the species identification of "atypical" mycobacteria, as well as drug susceptibility testing, are usually done by only a few larger laboratories.

On the other hand, the practicing physician would like to have certain laboratory procedures readily available so that he may know as soon as possible if mycobacteria are present in a specimen. This knowledge may not only be im-

portant for treatment of the patient but also for the protection of the patient's family and those caring for him. Because of these considerations and because fresh specimens are more likely to yield positive results, physicians often want a local laboratory to have the capability of identifying mycobacteria, especially *M. tuberculosis*.

In order to do this properly, the laboratory should be able to do acid-fast stains, set up cultures, and preferably, perform niacin tests. The latter test, if positive, nearly always identifies the organism as *M. tuberculosis*. It is important to differentiate disease caused by this organism from diseases caused by other mycobacteria, because diseases caused by "atypical" organisms have not been shown to be communicable and, therefore, do not require the precautions and contact investigation necessary when a case of tuberculosis is discovered.

In order to determine the practices of Oklahoma laboratories regarding mycobacteriology, a survey of these laboratories was begun in October 1973.

II. METHODS

A questionnaire was developed which would emphasize the most important aspects of mycobacteriology (Figure 1). After consultation with laboratory workers, it was decided that the questionnaire should be brief (one page) and easily understandable in order to get a response

RESULTS OF
MYCOBACTERIOLOGY QUESTIONNAIRE
2/18/74

Name of Laboratory (or Hospital, etc.) _____

Location _____

	Yes	No
1. Does your laboratory stain for mycobacteria?	121	102
2. Does your laboratory culture for mycobacteria?	82	141
OF THE 82 LABORATORIES DOING CULTURES, THE FOLLOWING RESPONSES WERE OBTAINED:		
3. Do you use the niacin test?	32	50
4. Does your laboratory identify the various Runyon groups of mycobacteria and <i>M. bovis</i> ?	16	66
5. Does your laboratory do biochemical tests to identify the different species of "atypical" mycobacteria?	15	67
6. Does your laboratory confirm any of the above findings with any other laboratory?	72	10
If so, what laboratory? _____		
7. Does your laboratory do drug susceptibility testing on mycobacteria?	4	78
If so, which drugs? _____		
8. Do you do your mycobacteriology work under an isolation or safety hood?	30	52
9. Is the vacuum on this hood checked frequently?	19	63
If so, by whom? _____		
10. Do you report all new isolations of <i>M. tuberculosis</i> to the state or county health department, or do you depend upon others (physician, nurse, medical records, etc.) to do this?		
Report directly	43	39
	(52)*	(30)

Comments:

*Total if credit is given for laboratories referring cultures to other laboratories that do report.

FIGURE 1

from as many laboratories as possible. The intent was to determine what types of procedures the laboratories were performing and no attempt was made in this questionnaire to determine the methods used.

The names and addresses of all laboratories in Oklahoma known to the Laboratory Service, Oklahoma State Department of Health were obtained. The questionnaire, along with a cover letter signed by the Oklahoma State Commis-

sioner of Health explaining the purpose of the questionnaire, was mailed to each laboratory on the list. Four weeks later a second letter was sent to those not responding. This was repeated in another month if no response was received. If there still was no response, a letter and a copy of the questionnaire were sent to a public health nurse in the area. She was asked to contact the laboratory personally in an effort to obtain the desired information.

The laboratories at the Oklahoma State Department of Health and Oklahoma State Sanatorium were not included in this survey.

III. RESULTS

Of 228 laboratories to whom the questionnaire was mailed, a response was obtained from 223 (97.8%). The responses to each question are shown in Figure 1. All 223 questionnaires were tabulated to obtain the responses shown for questions 1 and 2. The responses to questions 3 through 10 were tabulated only for those laboratories giving a "yes" response to question 2.

As can be seen, only 121 (54%) of the laboratories stain for mycobacteria. Thirty-nine (18%) do smears but do not culture. Eighty-two (37%) of the laboratories culture for mycobacteria. Sixteen (20%) of the 82 laboratories doing cultures identify "atypical" mycobacteria by Runyon group and fifteen identify the species.

All but ten laboratories (12.2%) doing cultures refer these cultures to some other laboratory for further identification and/or confirmation of previous test results. Forty-five of the seventy-two laboratories referring cultures use the Oklahoma State Department of Health Laboratory as their reference laboratory. A private laboratory in Oklahoma City was next in frequency with nine referring laboratories. Six referred cultures to out-of-state laboratories. Five laboratories in the Tulsa area referred cultures to the Tulsa City-County Health Department Laboratory. Other reference laboratories received referral cultures from one or two laboratories.

Only four laboratories in the state perform drug susceptibility testing on mycobacteria.

Of the 82 laboratories doing cultures, only 30 (36.6%) have an isolation or safety hood. Nineteen of these hoods are checked frequently to determine whether the exhaust fan is working

properly. (Two laboratories have hoods with UV light and no ventilation fans.)

Forty-three (52%) of the laboratories report positive results directly to the Oklahoma State Department of Health. When one considers that some laboratories may not report directly but refer cultures to laboratories that do, there are still apparently only 62.7% of laboratories that report findings through laboratory channels.

IV. COMMENTS

The response to the questionnaire was better than expected. Although it was necessary to make three mailings and a few visits, it is uncommon to get a 97.8% response in any survey conducted primarily by mail. We are grateful to the laboratories in the state for their cooperation. We interpret this response to mean that the questionnaire itself was acceptable in terms of brevity and clarity.

It was somewhat surprising that only 54% of the laboratories reported that they stained specimens to identify mycobacteria. The reason for such a low percentage of laboratories performing this test is unclear. It may be because some persons have the erroneous impression that, unless the newer fluorochrome technique is used, the results are unreliable.

In recent years the use of the fluorochrome staining technique has become more popular. While this technique is more sensitive and timesaving, especially if thirty or more specimens are processed daily, the special equipment required makes it an impractical and uneconomical technique for the small laboratory to perform.

The older Ziehl-Neelsen technique is relatively easy to perform, inexpensive, and of sufficient reliability to be used as an initial screening test when tuberculosis is suspected.³ If positive, a presumptive diagnosis can be made quickly, often saving the patient from further diagnostic tests and delayed or inappropriate treatment. We would encourage more laboratories, even small ones, to perform this test.

Although a smear done on a concentrated specimen which has been decontaminated, digested, and centrifuged has a higher yield of positive results, the direct smear still has clinical usefulness and can often be as good as a concentrated specimen, if material is carefully selected.⁴

In contrast to the above situation regarding staining of smears, more laboratories than ex-

pected (82) culture for mycobacteria. The reason for this is also unclear. It may be that many medical staffs and/or laboratory supervisors have encouraged laboratories to have this capability, even though cultures may be performed infrequently. Of interest in this regard is the fact that only 32 of the 82 laboratories doing cultures (39%) perform a niacin test. This is a relatively simple test and, as previously mentioned, if it is positive the organism nearly always is *M. tuberculosis*. If a laboratory can justify performing cultures for mycobacteria, it is reasonable to expect that laboratory to presumptively identify the organisms as *M. tuberculosis* by doing a niacin test.

From the responses to questions 4 and 5, it will be seen that 16 laboratories identify the four Runyon groups and 15 laboratories do biochemical tests to identify the species. Most of these laboratories are larger reference laboratories. Unless the species of mycobacteria growing in culture is identified, an erroneous diagnosis and inappropriate treatment may result, since not all atypical organisms are pathogenic. Therefore all isolations of atypical mycobacteria should be referred for identification. The expense and expertise required for performing the necessary biochemical tests make it impractical for all but the larger reference laboratories to perform them.

The response to question six indicates that all but 10 of the 82 laboratories performing cultures confirm their results with other laboratories. This is encouraging. However, two laboratories were found which did not do niacin or any other biochemical tests and which also did not confirm their findings with any other laboratory. These laboratories should either begin to refer their cultures or begin to do the procedures required to identify the species of mycobacteria if the physician receiving the results is to make an accurate diagnosis.

Only four laboratories reported doing drug susceptibility studies. This is certainly a sufficient number for the state. Here again, the expense and expertise required for these studies make it impractical for all but the larger reference laboratories to perform them. Three laboratories performed susceptibility tests to streptomycin, para-aminosalicylic acid, isoniazid, and ethambutol; two to rifampin; and one each to viomycin and ethionamide. One laboratory failed to state which drug susceptibility studies were done.

One explanation for the small number of laboratories doing niacin tests and other biochemical tests may be that only thirty laboratories reported having an isolation or safety hood. Laboratories without hoods may be reluctant to manipulate cultures or do niacin tests using cyanogen bromide. Apparently these laboratories are not reluctant to handle specimens and set up cultures. Tuberculosis is spread by the airborne route and unfortunately, many procedures in the laboratory can produce infectious aerosols even though cultures are not manipulated.⁷⁻⁸ It would appear from previous statements⁹⁻¹¹ that workers handling mycobacteria-containing specimens are at increased risk of developing active tuberculosis. Therefore, we would encourage all laboratories which regularly handle specimens for mycobacteriology work to utilize the safety measures which have been previously published.¹²⁻¹⁴

Of these thirty hoods, nineteen are checked frequently to determine whether the exhaust fan is functioning properly. Hoods should be checked every three months.⁵ The exhaust fan should have the capacity to draw a minimum of 50 to 75 lineal feet of air per minute across the entire front opening.⁶ Presumably nine hoods are not checked and may be ineffective.

In spite of the fact that reporting of tuberculosis is required, only 43 of 82 laboratories doing cultures report positive findings directly to the Oklahoma State Department of Health. The Oklahoma Public Health Code (Art. 5, Sec. 1-503) states "(a) The State Board of Health shall promulgate rules and regulations establishing a system of reporting cases of diseases diagnosed or detected by practicing physicians and/or clinical laboratories which come within the purview of this article. . .". If one considers indirect reporting, there are still only 52 laboratories that report their findings through laboratory channels. The other laboratories indicated that they depend upon others, primarily physicians, to report positive findings. While this is understandable, it often leads to delayed reporting or failure to report a case of tuberculosis.

Perhaps the reluctance to report findings directly results from a fear of violating the physician-patient relationship and/or the feeling that the laboratory cannot make a diagnosis but can only report test results. Regarding the first consideration, the patient-physician rela-

tionship should not take precedence when the law specifies that a communicable disease be reported. In addition, the policy of the Tuberculosis Division of the Oklahoma State Department of Health is to contact the private physician before contacting patients or their families. Secondly, the intent of the Oklahoma legislature was for laboratories to report positive findings, otherwise the statement "cases of disease . . . detected by . . . clinical laboratories" would not have been included in the Public Health Code.

The Oklahoma State Department of Health needs more rapid and complete reporting because it has the responsibility to (1) see that infectious cases are under treatment, (2) investigate contacts of active cases, and (3) collect information about the occurrence and incidence of tuberculosis in our state. If a case is not reported, the patient may be lost to follow-up and not receive adequate treatment if he moves or fails to return to his private physician. This could result in the infection of more persons with *M. tuberculosis*. These individuals then become the reservoir from which more active cases will develop in the years ahead. Examination of the contacts of active cases of tuberculosis is done to find others who might have been infected and may have active disease. This

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contact investigation may be neglected if the case is not reported.

V. CONCLUSION

The results of this survey indicate that (1) more laboratories should be staining slides for mycobacteria, (2) fewer laboratories should attempt to culture mycobacteria, (3) laboratories that do cultures should perform niacin tests, (4) more laboratories need safety hoods, (5) safety hoods in existence should be checked more frequently, and (6) direct laboratory reporting to the Oklahoma State Department of Health needs to be improved.

We encourage persons responsible for establishing laboratory policies and procedures to critically review their practices regarding mycobacteriology work. Some laboratories will need to change the types of procedures they perform and/or how they perform them. In this way the laboratory will assist the physician in making a more rapid and accurate diagnosis

and thus provide better treatment for the patient.

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¹Chief, Research and Development Branch, Tuberculosis Control Division, Bureau of State Services, Center for Disease Control, Atlanta, Georgia 30333. (At the time of this survey Dr. Snider was a Tuberculosis Medical Officer in the U.S. Public Health Service assigned to the Oklahoma State Department of Health.)

²Commissioner, Oklahoma State Department of Health.

Center for Disease Control, Atlanta, Georgia 30333

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DATE TITLE — SPEAKER

January 22, Pulmonary Disease II—C. Dowell Patterson, MD

January 29, Diabetes, Hypoglycemia and Calcium—James Males, MD

February 5, Metabolic and Respiratory—Robert D. Lindeman, MD; Acid Base Disturbances—Chris E. Kaufman, MD

February 12, Glomerulopathies Diagnosis and Management—Solomon Papper, MD; Anil K. Mandal, MD

February 19, Urinary Tract Infection and Stones; Diagnosis and Management—Anthony Czerwinski, MD

February 26, Infectious Disease I—Infectious Disease Section.

March 5, Infectious Disease II—Infectious Disease Section

March 12, Valvular Heart Disease—Eliot Schechter, MD

March 19, Gastroenterology I—Gastroenterology Section

March 26, Congenital Heart Disease In The Adult—Lofty L. Basta, MD

April 2, ASCVD and Cardiomyopathies—Stephen D. Shappell, MD

April 9, Gastroenterology II—Gastroenterology Section

April 16, Metabolic Disorders Presenting In The Adult—Sylvia Bottomley, MD

April 23, Pituitary Adrenalin and Endocrine Hypertension—David C. Kem, MD

April 30, Thyroids and Gonads—E. William Allen, MD



News From The Oklahoma State Department of Health

PKU REVISITED

Although phenylketonuria is a rare inborn error of metabolism, enough children have been successfully managed to be optimistic about the results. Therefore, we must improve our diagnostic methods to avoid a tragic oversight. True to the maxim that more mistakes are made by not looking than not knowing, we should check every newborn infant. Using the Guthrie test as a screening procedure is not enough. As a screening test it has limitations which are magnified by drawing the specimen under 72 hours of age and in cases where the initial protein intake may be in question because of dif-

ficult early feeding. One can expect false positive tests in any procedure used for screening and, troublesome as it may be, a false positive is easier to explain than a false negative.

Please consider rechecking all infants with an initial Guthrie test of over 4 mg % *immediately*, not waiting until four to six weeks of age. Also, plan to recheck infants who were tested before 72 hours of age. Seriously consider rechecking babies who had trouble feeding or in breast fed babies with questionable intake. Some physicians are repeating the Guthrie test at the routine one month checkup.

The intelligence and behavior of an affected child seems to be optimal when limited dietary phenylalanine therapy was started under 21 days of age. The Oklahoma State Department of Health is ready to assist you in the early diagnosis of this treatable disorder. Treatment centers are available at Tulsa's Children's Medical Center, and in Oklahoma City through Children's Memorial Hospital. □

COMMUNICABLE DISEASES IN OKLAHOMA FOR NOVEMBER, 1974

DISEASE	November	November	October	Total To Date	
	1974	1973	1974	1974	1973
Amebiasis	3	1	2	27	29
Brucellosis	2	—	2	11	5
Chickenpox	129	15	61	1006	1331
Encephalitis, Infectious	4	3	8	55	101
Gonorrhea (Use Form ODH-228)	970	752	1072	10385	9995
Hepatitis, A, B, Unspecified	117	64	62	950	1053
Leptospirosis	1	—	—	2	—
Malaria	—	—	3	6	3
Meningococcal Infections	2	1	1	18	34
Meningitis, Aseptic	5	2	3	63	103
Mumps	24	10	9	405	468
Rabies in Animals	13	5	16	155	155
Rheumatic Fever	—	2	1	12	16
Rocky Mountain Spotted Fever	6	—	4	66	76
Rubella	8	1	3	66	182
Rubella, Congenital Syndrome	—	—	—	1	—
Rubeola	—	5	2	29	61
Salmonellosis	18	15	34	255	263
Shigellosis	24	9	12	174	185
Syphilis, Infectious (Use Form ODH-228)	12	15	12	133	160
Tetanus	2	—	—	3	4
Tuberculosis, New Active	12	29	43	271	302
Tularemia	—	1	4	18	23
Typhoid Fever	—	—	—	2	2
Whooping Cough	3	—	—	19	21

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Dues and Finances Dominate AMA House of Delegates Meeting

Extended debate, often heated, took place during the American Medical Association's 28th Clinical Convention in Portland, Oregon, November 30th-December 4th. The dispute revolved around the financial situation of the AMA.

The house was reminded that the AMA had operated at a deficit for four of the last five years, and that its cash reserves had been seriously depleted during that time. In addition, AMA finances in 1974 were adversely affected by inflationary pressures.

After almost six hours of comment and deliberation on Tuesday afternoon and Wednesday morning, the delegates adopted a \$60 special assessment as a stop-gap measure. The mandatory assessment, effective January 1st, will be billed from the AMA Washington office to all members, excluding students, interns and residents.

The \$60 assessment is expected to improve the immediate cash flow problems for the association and to help build up its depleted financial reserves.

The house rejected a \$90 dues increase proposed by the AMA's Board of Trustees. In doing so, however, they called for a special committee of the house to study the dues issue and report back at the 1975 Annual Meeting in Atlantic City. The committee will make a comprehensive study of the AMA's financial priorities and capabilities. In the meantime, the house urged the board to restore in a "holding pattern" the structure of several councils and committees which it had previously eliminated, and to maintain present publication schedules for *JAMA*, all specialty journals and *Prism*.

In a related issue, the house approved advertising as a legitimate function in AMA publications, and urged that the present full and unrestricted advertising program in AMA publications continue pending further study and a report at the June meeting.

Meeting a total of 16 hours and 40 minutes, one third of it devoted to the AMA finances

and related issues, the delegates acted on 77 reports and 68 resolutions for a total of 145 items of business. The following is a brief description of some of the highlights of the meeting.

Harry Schwartz, PhD, visiting professor of Medical Economics at the Columbia University College of Physicians and Surgeons was selected to receive the AMA's Laymens' Citation for Distinguished Service. Doctor Schwartz is on leave from the Editorial Board of the New York Times and is the author of the *Case for American Medicine*.

Doctor Schwartz will be presented his award at the 1975 Annual Meeting in Atlantic City. Last year he was a guest speaker during Oklahoma Medical Summit, the combined annual meeting of the OSMA, Oklahoma Academy of Family Physicians and the Oklahoma City Clinical Society.

During a discussion of malpractice problems, the house adopted a recommendation calling for the board to give "priority attention" to providing legal counsel and advise to AMA members and state societies in the event their professional liability insurance is not renewed. The necessity for state associations to seek legislative remedies for malpractice problems was emphasized.

A separation of the fall business meeting of the house and the scientific meetings will be permitted beginning in 1977. Under new by-laws changes the house will hold its fall meeting separately in cities recommended by the Board of Trustees and selected by the house, and the scientific session will hold regional meetings at other times during the years deemed necessary by the board and at cities selected by the board. This new format was devised to allow regional scientific programming. The scientific assemblies will continue to be held in conjunction with the annual meetings, however.

Strong programs of continuing medical education and peer review as alternatives to re-

licensure were called for by the house. Specific recommendations included all possible encouragement for medical professional organizations to expand the continuing medical education programs. Well designed peer review programs would be endorsed as an important component of performance evaluation, the house stressed performance evaluation, rather than knowledge *per se*, as the best method of appraising competence in patient care.

A vote of confidence was given to the Board of Trustees by the delegates for its effort to develop new approaches to National Health Insurance while maintaining traditional AMA goals. The house adopted a board report containing basic guidelines for NHI deliberations. (These guidelines are outlined in another article in this issue of *The Journal*.)

A strong policy position against the use of human chorionic gonadotropin for use in weight reduction was taken. The house resolved, "that the AMA warn our citizens about the potential danger of such weight control programs." Clinics utilizing chorionic gonadotropin have been established and widely advertised in various parts of the country, including Oklahoma City.

An AMA policy to encourage insurance coverage of the newborn from the moment of birth was reaffirmed by the delegates. They urged the Health Insurance Industry to offer coverage for obstetrical care and any complications, and recommended that the insurance industry, as well as government, offer such coverage on the broadest possible basis.

State legislation to regulate the practice of acupuncture was supported by the delegates. A new policy says acupuncture should only be performed in research settings by a physician or under the direct supervision of a physician.

The house again objected to language in insurance letters indicating that claims were "not medically necessary," since this encourages patients to decline to pay for services and is defamatory to physicians.

The present 55-mile per hour speed limit was endorsed by the house while delegates urged the government to continue the reduced limit for at least a one-year period. It noted that traffic fatalities have declined 14.8% since the speed limit was imposed last year.

A proposal to replace the Council on Legislation and many functions of the American Medi-

cal Political Action Board of Directors with a new Council on Public Affairs was soundly defeated by the House of Delegates. Although it was proposed by the AMA's Board of Trustees, many delegates felt that the AMPAC Board should remain separate from functions of the AMA. □

Washington Political Profile for 1975

There can be little doubt that the 1974 elections changed the political profile of the nation's capital. Going into the election the United States Senate held 58 Democrats and 42 Republicans while the House of Representatives had 248 Democrats and 187 Republicans.

Following the November elections it was clear that the Republicans had suffered numerous defeats, but had not given the Democrats the landslide victories that they anticipated. On November 5th, 34 Senate seats were contested, of which 20 were held by Democrats and 14 by Republicans. Of the 20 Democrats, three were unopposed. On election day, four seats formerly held by Republicans were captured by Democrats and one seat formerly held by a Democrat was captured by a Republican for a net gain of three Democratic seats.

In 1975 the United States Senate of the 94th Congress will hold 61 Democrats and 38 Republicans.

All members of the House of Representatives run every two years. In the 435 House races, 44 candidates were unopposed. On election day, 49 seats formerly held by Republicans were taken by the Democrats and six seats formerly held by Democrats were captured by Republicans. This gives the Democrats a net gain of 43 House seats so that House lineup for the 94th Congress will be 291 Democrats and 144 Republicans. (At the time of this writing one House seat in Louisiana is still being resolved.)

In state governor races, Democrats went into the elections with 31 governors' chairs while the Republicans held 19. Following the elections, the Democrats held 31 chairs, the Republicans retained only 13, and one Independent was elected. This was a net gain of five Democratic governorships. □



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Ford Announces Administration's Health Insurance Plan

President Gerald Ford has indicated that the National Health Insurance Plan his administration will submit to the next Congress will be similar to former President Nixon's Comprehensive Health Insurance Plan, known as CHIP. In a legislative message to the lame duck congress in late '74, Ford made it clear he expected no action during that year and that he wanted Congress to wait to see his plan.

CHIP was based on mandatory coverage of workers by employers through the existing private health insurance system. While the original plan had very little congressional support, it was highly favored by the HEW leadership.

In the meantime, HEW Secretary Casper Weinberger has been meeting with the principle medical and health care providers, including the AMA, in an effort to arrive at some sort of consensus with respect to an NHI Bill.

The AMA has provided the secretary and other organizations with a 14 point set of principles that it believes essential to any national health insurance plan. Approved by the AMA's Board of Trustees, these NHI guidelines are as follows:

1) Minimum federal involvement in administration of any national health insurance program . . .

2) State jurisdiction with respect to licensure and certification of professional health personnel and regulation of insurance . . .

3) Minimum federal dollars in financing of programs for comprehensive coverage at the least possible cost . . .

4) Funding through federal, state and private funds including employer-employee contributions for private health insurance and an individual tax credit as applied for full health care protection . . .

5) No added Social Security tax for financing . . .

6) No administration by the Social Security Administration . . .

7) Cost sharing by participating individuals and families and a subsidy for the indigent scaled according to income . . .

8) Use of private insurance on risks and underwriting basis . . .

9) Comprehensive coverage, basic and catastrophic, for the entire population . . .

10) Pluralism in methods of health care delivery . . .

11) Cost controls as appropriate . . .

12) Quality controls as appropriate . . .

13) Continuity of benefits . . .

14) Coordination of benefits. ☐

Tulsa Possible Site For AMA Regional Meeting

Tulsa has been selected by the AMA's Council on Scientific Assembly as a potential site for a Regional Continuing Medical Education Meeting in 1976.

Regional meeting sites are chosen on the basis of physician-population, ease of transportation access, and availability of physical facilities and course faculty. The council has tentatively selected the month of January, 1976, for a Tulsa presentation.

The regional meeting is presented on a Saturday-Sunday weekend to minimize the physician time away from his practice. Each meeting is composed of six to eight post-graduate courses on broadly related clinical topics.

It is possible for a physician to take two courses with a total of 12 hours of Category I Continuing Medical Education credit toward the AMA's Physicians Recognition Award.

An all encompassing fee "package" is available to cover room, food and registration. The fees are collected by the AMA which also bears the cost of planning and putting on the meeting.

The concept of the regional Continuing Education Meeting is part of an expanded program for which the Council on Scientific Assembly of the AMA is responsible. The council is the AMA's principle programming arm in Continuing Medical Education, an outgrowth of its traditional responsibility for programming the scientific and education portions of the AMA Annual and Clinical Conventions.

During the Portland Clinical Convention the AMA's House of Delegates moved for the separation of the Fall Business Meeting of the house and the scientific meetings. This will begin in 1977. It is anticipated that the scientific meetings of the Clinical Convention will be replaced by the Regional Continuing Education Programs. The scientific assemblies will continue to be held in conjunction with the annual meeting, however. ☐

Medical Information Confidentiality Stressed

Confidentiality of medical information, in light of computer technology and vast government involvement in health delivery, is becoming a national concern. The most recent voice heard was that of the American Medical Record Association during its annual meeting in San Francisco.

A position paper outlining the association's stand on medical information was adopted by its House of Delegates. The paper, as originally published, is as follows:

"The American Medical Record Association throughout its history has recognized the patient's right to privacy in relation to his medical record. While the patient does not have the property right to his record, he does have the protected right of information.

"The primary purpose of the medical record is to document the course of the patient's health care and to provide a medium of communication among direct care professionals for current and future patient care. Unless the patient can feel assured that the highly sensitive and personal information he shares with health care professionals will remain confidential, he may withhold information critical to his treatment, thereby diminishing the quality of the care provided him.

"Economic and social issues, together with technological advances, have resulted in an erosion of the confidential relationship traditionally existing between patient and health care professional. Substantiation of claims for payment has generated an ever increasing number of requests for information from patient health records. At the same time, the tremendous growth of computerized health data, the development of huge data banks and the advancement in record linkage pose an enormous threat to the privacy of medical information. The public is generally unaware of this threat or of the serious consequence of a loss of confidentiality in the health care system. Adequate measures to control medical privacy in the light of electronic information processing can and must be established.

"The American Medical Record Association recognizes the need for patient health information in providing a sound basis both for substantiating claims and for conducting medical care evaluation. Therefore, subject to applicable legal provisions, release of any individually

identifiable medical information for any purpose other than patient care must be done only with the expressed authorization of the patient or his legal agent.

"Further, AMRA recommends greater emphasis on the patient's right to privacy by health care institutions through the establishment of written policies for the release of information, together with active educational programs for all staff personnel, to enforce these policies.

"With respect to the right of privacy, AMRA, urges the development and implementation of programs to: (1) protect the patient from invasion of privacy as a result of indiscriminate and unauthorized access to confidential health information and (2) promote applicable usage of medical information once it is disseminated to authorized persons." □

San Antonio To Host International Medical Assembly

Historic San Antonio will play host for the International Medical Assembly of Southwest Texas. The 39th Annual Meeting will be held in San Antonio's Saint Anthony Hotel and the University of Texas Medical School, Thursday and Friday, February 27th and 28th.

This year's program is dedicated to the American Academy of Family Physicians, with built in interest for the specialists. Nine outstanding guest speakers have been obtained along with panels composed of local experts from the University of Texas Medical School at San Antonio, Wilford Hall Medical Center, Brooke Army Medical Center and the Bexar County Medical Society.

At the conclusion of the two-day convention, the annual extension trip will be to Acapulco and Mexico City. This trip has become an integral part of the postgraduate medical seminar and the number of physicians and their wives going on the trip has increased every year.

Distinguished speakers for the Medical Assembly include an Oklahoman, David C. Kem, MD, an Oklahoma City internist.

Persons interested in receiving additional details should write Mr. Sid Cockrell, Jr., Executive Director, P.O. Box 12678, San Antonio, Texas 78212. □

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One-Third of Health Dollars Spent By Government

Of every health care dollar spent in this country, 33 cents is being provided by the federal government, according to a unique report made annually by the AMA's Washington office.

Actual dollar outlays in any given year may vary considerably from the appropriations provided by Congress, but the appropriations figure used by the AMA is an accurate guideline of the nation's year to year health spending.

During the fiscal year that ended last July, the federal government disbursed more than \$32.7 billion for health, up \$2.6 billion from the previous year, plus more than \$12 billion for disability programs. Total spending from all sources on health was estimated at about \$100 billion.

The federal tab for the current fiscal year, ending in July, 1975, is slated to register a sharp jump as new federal programs get going and increased overall health care costs are reflected.

As was to be expected, the HEW Department leads the list of government health spenders with \$23.7 billion appropriated last fiscal year for its many health activities including Medicare and Medicaid. Next in line were defense and veterans administration, each spending over \$3 billion.

Fourth and fifth slots are occupied by relatively recent federal activities, the Federal Employees Health Insurance Program and the Environmental Protection Agency, with \$696 million and \$528 million respectively.

Animal disease control, research, meat inspection, and a few other lesser activities under the Department of Agriculture add up to \$302 million per year. Even though it might be considered a health cost, the AMA did not count \$7.8 billion for health related programs of food for school children, and rural housing, water and waste disposal activities.

Medicare is the single largest federal health plan moneywise though financed out of Social Security taxes. Technically, Medicare remains an appropriation that must be approved by Congress each year. Last fiscal year Medicare spent \$12.1 billion, a \$2.5 billion increase due to increased utilization, higher costs, and a new program for the dis-

abled, including kidney disease patients, which accounted for an additional \$1.25 billion.

Of the Medicare total, almost \$3 billion was paid out for the supplemental insurance plan for outpatient benefits. Half of the premium is paid for by the beneficiaries.

The federal government allotted \$5.8 billion to the states for the Medicaid Program for medically indigent people, an increase of almost \$1 billion due to expansion of categories eligible for such assistance. If federal, state and local funds are counted, Medicaid cost \$10.5 billion. □

Medicare Deductible Up For 1975

The Department of Health, Education and Welfare has announced that commencing with the first of the new year the medical hospital deductible will jump to \$92. The present deductible is \$84.

HEW said that the \$92 deductible is equivalent to the average cost of one day of hospitalization. The increased payment was brought about by rising hospital costs, according to the department.

The Medicare law requires an annual review of hospital costs under Medicare and an adjustment of the portion of the bill for which a Medicare beneficiary is responsible, if the costs have risen substantially.

When the hospital deductible amount changes, the law requires comparable changes in the dollar amounts that a Medicare beneficiary pays toward a hospital stay for more than 60 days, or an extended care facility stay of more than 20 days.

Now, if a Medicare beneficiary has a hospital stay of more than 60 days, he will pay \$23 a day for the 61st through the 90th day, up from the \$21 per day charged in 1974. If he has a post-hospital stay of over 20 days in the extended care facility, he will pay \$11.50 per day toward the cost of the 21st through the 100th day, up from the \$10.50 per day charge in 1974.

If it becomes necessary for a beneficiary to dip into his "lifetime reserve" of hospital days, the extra 60 hospital days the beneficiary can use when he needs more than 90 days of hospital care in any given benefit period, the extra use will cost him \$46 for each reserved day, instead of the present \$42 per day. □



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Fifty Years of Medical Practice



Doctor Coker has had the privilege of delivering many children in and around Durant. Among those whom he has watched grow to maturity are pictured above (l to r) Betty (Harlin) Bowen, Kathryn (Harlin) Melson, Doctor Coker, J. D. Harlin, B. B. Newton, Georganna (Harlin) Black, behind her, Henry George Wells, Ben Wells, Dwayne Wells, Bob Wells and John Wells.

Batley B. Coker, MD, Durant, has had many experiences in his fifty years of practice in southeast Oklahoma. Doctor Coker arrived in Durant on March 15th, 1926, after a five-day train trip from California. He had originally planned to form a partnership with another Durant physician and equally share their income. However, upon learning that the largest income the other physician had received in any given month was \$80, he decided to establish his own practice. At the time, Durant had 25 physicians and a population of 7,400 and Doctor Coker found his specialty, ophthalmology, was not very lucrative, so he entered general practice.

He underwent many trying times such as making a house call in the middle of a cold, foggy, February night at Bee, Oklahoma. He could drive his car only as far as Nida, Oklahoma, and had to ride horseback to Bee. This was a two-hour ride. Arriving at the home, he found a patient with kidney stone colic and it was 3:00 a.m. before he was ready to return to Durant. However, he was told that everyone had gone to bed and there was no one to take him on horseback to his car in Nida. He was forced to spend the rest of the night in the patient's home.

Another time he drove as far as he could and then walked a mile on a muddy road to aid a 78-year-old patient. It developed that her appendix had ruptured. An operating table was

set up in the kitchen of the home and emergency surgery was performed. As Doctor Coker pointed out later "... to everyone's surprise, the patient survived and lived for many years."

In his early practice all obstetrical cases were delivered at home.

It was not unusual during a good cotton-crop year for Doctor Coker to collect unpaid bills dating back several years.

His practice was interrupted during World War II when he served as a Lieutenant (jg) in the Medical Corp of the US Navy.

In 1965, the physician closed his office and returned to school for postgraduate training in his specialty. Following two and one-half more years of practice, he retired. However, he said, "I found out house work was harder than practicing . . ." so he accepted a position at Southeastern State College doing consulting examinations.

Doctor and Mrs. Coker have two daughters, six grandchildren and four great grandchildren. He is a Life Member of the OSMA, a member of the American College of Surgeons and the Southern Medical Association. □

DEATH

ELIZABETH M. CHAMBERLIN, MD
1883-1905

A 91-year-old Bartlesville physician, Elizabeth M. Chamberlin, MD, died December 10th, 1974. A native of Nebraska, Doctor Chamberlin was graduated from Creighton University School of Medicine in 1905. Her practice was established in Bartlesville in 1917. In 1937, she became a charter member of the Diplomates of the American Board of Pathology.

Doctor Chamberlin was presented a Life Membership in the OSMA in 1951. □

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New "Doctor's Office" In The State Capitol

Each year the OSMA, in conjunction with the Oklahoma State Nurses Association, sponsors a Legislative Doctor and Nurse of the Day Program during the annual legislative sessions. While 1975 will be no exception, there is something new. . . a new office for the doctor and nurse located on the third floor of the capitol.

When the program first started, approximately 12 years ago, the "doctor of the day" did not have an office. He would simply come into the capitol building and tell the receptionist for the House of Representatives and the State Senate who he was and where he could be found during the day.

As an outgrowth of their appreciation, State Legislators began to insist that the doctor be given an office somewhere in the building. The first such office was a plywood, one room, "shack" constructed in one of the large open

spaces on the fourth floor of the capitol building. Later the office was moved to a real office on the fourth floor of the capitol building; it has built in shelves and storage areas for the doctors paraphernalia. The main drawback with both of the early offices was that there were no water facilities in them.

The new office is being constructed in the southwest corner of the third floor of the capitol building in what had been a janitorial room. The room is being completely redone and partitioned into an examining area and waiting room. Special lighting and storage facilities are being installed for the doctor and nurse of the day. However, the most important single new item is the availability of water.

Physicians from throughout the state are asked to serve one day during each legislative session as the "doctor of the day." The nurses association also has volunteers from throughout the state.

The doctors office is well stocked with pharmaceutical and first aid supplies donated by various manufacturers and companies. □

BOOK REVIEWS

Functional Anatomy of the Newborn. By Edmond S. Crelin, PhD, 87 pp, Yale University Press, New Haven, Connecticut, 1972. \$8.00

The author enunciating the principle that "the newborn infant is not a miniature adult" was unable to find such description in the literature and thus prepared his book for those who evaluate the neonate. This is a concise description of the anatomical features of the newborn infant. It is divided into some 60 subject headings such as larynx, bronchi and alveoli, heart and eye, to name a few. There are no references. Three figures accompany the text. Physiological and some histologic aspects are loosely included in the anatomic descriptions, but are too superficial to be helpful in most cases. Organ weights with some ranges are given for most major organs. The author, a professor of anatomy, is an experienced writer with a concise, clear style. The book will be helpful in the education of students meeting the newborn for the first time, and for nurses. *Harris D. Riley, Jr., MD*

Mental Retardation, by Louis B. Holmes, MD, 430 pp, MacMillin Company, New York, New York, 1972. \$28.00

In recent years there has been dramatic expansion of knowledge and elucidation of the pathogenetic mechanisms underlying a number of syndromes and disorders characterized by abnormal mental development. This particular book is the most complete and informative of the recent publications in this field. More than 170 syndromes are described. In each instance, the discussion is brief and timely and includes a review of physical abnormalities, nervous system aspects, pathological findings, treatment and prognosis, differential diagnosis and genetic aspects. The various syndromes are well illustrated with a variety of different photographs.

Although expensive, the book should serve as a standard reference for physicians and others concerned with the problem of mental retardation. *Harris D. Riley, Jr., MD* □

Miscellaneous Advertisements

EXCELLENT OPPORTUNITY for general practice in nice community near Lake Eufaula. Privileges in modern 44-bed hospital. Space available for three GP's in clinic adjoining hospital that already has an abundant patient load. Can expect full-time practice in a short time, along with time off coverage. Guaranteed starting salary — very rapid chance of advancement — with capabilities of earning up to \$50,000.00 yearly. Located in an ideal community from which the patients are drawn from an area of approximately 20,000 population. Ideally located on Highway I-40 and IS-75 — an hour's drive to Tulsa theaters and restaurants and only an hour and a half from downtown Oklahoma City. Only a few minutes drive to Lake Eufaula, Fountainhead Lodge being only 25 miles away. There is a new high school and a new grade school. A small town having all the advantages of a city. A wonderful place for raising children. This is a marvelous opportunity for a family type practice with time off. Call Carlton E. Smith, MD, 918 652-3337, Henryetta, Oklahoma, collect.

ONE, TWO OR THREE PHYSICIANS NEEDED. Would like to retire. Clinical facilities with lab and x-ray. Especially good for general practitioner, orthopedist, ophthalmologist, pediatrician or could be easily converted to accommodate any field of medicine. Overflow parking space available. General surgery instruments, some orthopedic, few nose and throat and several miscellaneous instruments and equipment. One-hundred bed hospital; new hospital to open in November, 1975 with 145 beds. Make \$30,000 easily; could make \$100,000. Good clientele. Oklahoma State University with over 19,000 enrollment as asset. Located between Tulsa and Oklahoma City with connecting four-lane highway under construction. Good hunting and fishing. Physicians interested in coming to a clean, educational city with a population of 32,800, contact A. B. Smith, MD, 408 S. Main, Stillwater, Oklahoma 74074. Phone 405 372-5656 (office) or 405 372-6460 (home.)

DUE TO THE RECENT RETIREMENT of one of our local general practitioners, and moving of another physician, we have two office spaces for rent. Each consists of waiting room, two examining rooms and private office. For more information contact E. D. Greenberger, MD, Medical Arts Building, McAlester, Oklahoma. Phone 423-1432.

NEWLY CONSTRUCTED, multi-specialty clinic in Lubbock, Texas has openings in areas of OB-GYN, Internal Medicine and Family Practice. New 120-bed hospital adjacent to clinic. Top salary leading to partnership. Interested applicants send curriculum vitae to University Medical-Surgical Clinic, 6602 Quaker Avenue, Lubbock, Texas 79414. □

Second Annual Hair Transplant Symposium and Workshop

February 14th-15th, 1975

Hot Springs, Arkansas

Co-sponsored by the American Academy of Dermatologic Surgery and the American Academy of Facial Plastic and Reconstructive Surgery, Inc.

Further information may be obtained from William G. Irwin, MD, The Stough Dermatology and Cutaneous Surgery Clinic, PA, Doctor's Park, Hot Springs, Arkansas 71901.

64th
ANNUAL MEETING

INTERNATIONAL

ACADEMY OF

PATHOLOGY

March 4th—8th, 1975

New Orleans, Louisiana

Marriott Hotel

The annual Maude Abbott lecture entitled "Pathology and Preventive Medicine" will be delivered on Wednesday, March 5th, by Doctor John Higginson, Director, International Agency for Research on Cancer, Lyon, France.

In addition there will be 80 scientific papers, six pathology specialty conferences and 48 short courses.

Additional information is available from Mrs. J. Preston, IAP Registrar, Armed Forces Institute of Pathology, Room 4090, Washington, D.C. 20306. Telephone 202 576-2969.

PRESCRIBING INFORMATION
Antiminth (pyrantel pamoate) Oral Suspension

Actions. Antiminth (pyrantel pamoate) has demonstrated anthelmintic activity against *Enterobius vermicularis* (pinworm) and *Ascaris lumbricoides* (roundworm). The anthelmintic action is probably due to the neuromuscular blocking property of the drug.

Antiminth is partially absorbed after an oral dose. Plasma levels of unchanged drug are low. Peak levels (0.05-0.13 µg/ml.) are reached in 1-3 hours. Quantities greater than 50% of administered drug are excreted in feces as the unchanged form, whereas only 7% or less of the dose is found in urine as the unchanged form of the drug and its metabolites.

Indications. For the treatment of ascariasis (roundworm infection) and enterobiasis (pinworm infection).

Warnings. *Usage in Pregnancy:* Reproduction studies have been performed in animals and there was no evidence of propensity for harm to the fetus. The relevance to the human is not known.

There is no experience in pregnant women who have received this drug.

Precautions. Minor transient elevations of SGOT have occurred in a small percentage of patients. Therefore, this drug should be used with caution in patients with pre-existing liver dysfunction.

Adverse Reactions. The most frequently encountered adverse reactions are related to the gastrointestinal system.

Gastrointestinal and hepatic reactions: anorexia, nausea, vomiting, gastralgia, abdominal cramps, diarrhea and tenesmus, transient elevation of SGOT.

CNS reactions: headache, dizziness, drowsiness, and insomnia. Skin reactions: rashes.

Dosage and Administration. *Children and Adults:* Antiminth Oral Suspension (50 mg. of pyrantel base/ml.) should be administered in a single dose of 11 mg. of pyrantel base per kg. of body weight (or 5 mg./lb.); maximum total dose 1 gram. This corresponds to a simplified dosage regimen of 1 cc. of Antiminth per 10 lb. of body weight. (One teaspoonful = 5 cc.)

Antiminth (pyrantel pamoate) Oral Suspension may be administered without regard to ingestion of food or time of day, and purging is not necessary prior to, during, or after therapy. It may be taken with milk or fruit juices.

How Supplied. Antiminth is available as a pleasant tasting caramel-flavored suspension which contains the equivalent of 50 mg. pyrantel base per ml., supplied in 60 cc. bottles and Unitcups™ of 5 cc. in packages of 12.

1974 has been a very busy year for many auxiliary members, who took an active part in their areas in helping the candidates they felt best represented the views of physicians. However, now that the election is over, much more work remains to be done on the legislation which is being written, studied and acted upon by the men we have sent to Washington and to Oklahoma City.

Our job now is to keep in contact with these men, be informed on what is taking place on the state and national level and take necessary action on a moment's notice when needed to help influence their vote on certain bills, not because of selfish interest but in the interest of the future delivery of quality medicine and its effect on the lives of doctors, as well as the people of America.

To be ready to do this job we would like to have the "Legsline" at a better stage of development in Oklahoma. The *LEGSLINE* Alert System has been developed to ensure quick and effective communication between all Legs participants.

The system can operate on a letter writing basis for transmitting up-to-date information implementing any member of public affairs projects or reporting results of completed projects. In the event of an emergency the alert can be done by phone. For optimum organization, there should be at least one *LEGSLINE* Alert Chairman for every ten auxiliary members in the state. There is no limit to the number of subchairmen but there should be as many as are needed. It cannot be emphasized enough how effective and important this organization can be

but it will take your cooperation to get it started.

A must is knowing what all of the initials stand for—for example: PSRO—Professional Standards Review Organization. HMO—Health Maintenance Organization. NHI—National Health Insurance.

Mark your calendar: March 5th, 1975 "A Day at the Legislature." Special plans were made last fall for you to spend a day becoming acquainted with your State Legislature. In some areas it would be best to charter a bus, which would really be a lot of fun. Smaller areas could get together in car-loads and come. Just make sure you plan to attend—you won't be sorry—it will truly be a day well spent.

Each year more and more laws are being written at both the national and state levels that concern health, health-care and the delivery of health-care. If we don't take an interest now, laws will be passed that may not have the doctors' and patients' best interest in mind.

When someone asks you to serve as a chairman in your area to help us get our "LEGS" organized, say yes. The success of our effort rests completely in your hands. Don't let us down.

Just one last word. If you have not yet joined AMPAC-OMPAC, do so today. This is your American Medical Political Action Committee and the Oklahoma Medical Political Action Committee. Through these organizations, friends of medicine are assisted when they run for office. We need your financial support and personal interest in these organizations. *Respectfully Submitted, Shirley Forsythe, Legislation Chairman* □

Malpractice law suits are growing. According to a recent publication from the St. Paul Fire and Marine Insurance Company, "one of every ten US physicians insured (by that company) currently has a malpractice claim pending against him. The number of claims pending has more than doubled since 1969." In that year only one out of every 23 of the company's insureds had claims pending with an average reserve of only \$6,705. As of September 30th, 1974, the average claim reserve was \$12,534. The publication stated editorially, "the result is that the nation is dangerously close to having no malpractice insurance available at any price. Private insurance carriers cannot indefinitely sustain current losses from malpractice underwriting. Physicians cannot sustain premiums of \$10,000 to \$12,000 per year and more without passing the cost along to the already hard pressed consumer."

All regular AMA publications, except JAMA, American Medical News, and Today's Health, will now be on a subscription basis for members as well as non-members. The action was taken by the AMA's Board of Trustees at its meeting in Portland, Oregon. The AMA publishes ten specialty journals. In the past, each regular AMA member was entitled to one specialty journal plus the above named publications, free of charge.

Hawaii in the fall is being planned for some lucky Oklahoma physicians. The OSMA is sponsoring a nine-day tour to the AMA's Convention in Honolulu November 28th-December 7th. The trip includes a two-day tour to Maui and six days in Honolulu for the AMA Meeting. Additional details will be announced as plans are completed.

An Oklahoma representative, James R. Jones, has been named to the newly expanded House Ways and Means Committee of the United States House of Representatives. When Wilbur Mills, the Arkansas Democrat, resigned his 17-year leadership of the committee, the Democratic Caucus expanded the committee mem-

bership from 25 to 37. Al Ullman, an Oregon Democrat, has been nominated to succeed Mills as Chairman. Jones is one of 12 new members named to join the 13 Democratic holdovers.

A priority mission of the newly expanded House Ways and Means Committee will apparently be to produce a National Health Insurance Plan. Al Ullman stated that he was opposed to a Social Security financed National Health Insurance Plan and went on to say, "I don't believe in payroll taxes, but we'd have to find some other financial mechanism. I think it would be a disaster to dip into general revenues."

One victim of the AMA's \$60 assessment was the unified membership voted last May by the Medical Society of New Jersey. During its Annual Meeting the New Jersey House of Delegates had voted in favor of compulsory AMA, state and county membership. At a special session of the house on December 8th, immediately after the AMA's Portland meeting, the New Jersey delegates reversed their decision and voted down unified membership.

Volunteers to serve as Legislative "doctor of the day" are being sought by the OSMA. Physicians interested in serving one day as the doctor for members of the Oklahoma House of Representatives and State Senate should contact the OSMA office in Oklahoma City. The Legislature meets Monday through Thursday of each week and will probably be in session until late May.

A bill to overhaul Oklahoma's program of Aid to Families with Dependent Children (AFDC) is being considered by the State Legislature. Authored by Terry Campbell, a Representative from Bethany, Oklahoma, the bill would require an AFDC applicant to produce an affidavit from the State Employment Security Commission that there was no work available paying the federal minimum wage which the applicant could perform and which met federal health and safety standards. The measure would also set up a community service program and would require any able bodied AFDC recipient to work 80 hours a month in public or social services unless he is in a manpower training program. Campbell said that the average Oklahoma recipient stays on the welfare rolls for more than 18 months. A similar law enacted in the state of West Virginia has cut the length of stay to six months. □

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(Cover Art by William Cason)



AIR...a basic need for life support.

LUFYLLIN (dyphylline)

Before prescribing, please review complete product information, a summary of which follows:

Indications: For relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

Precautions: Exercise caution with use in the presence of severe cardiac disease, renal or hepatic malfunction, glaucoma, hyperthyroidism, peptic ulcer, and concomitant use of other xanthine-containing formulations or other CNS stimulating drugs.

Adverse Reactions: May cause nausea, headache, cardiac palpitation and CNS stimulation. Postprandial administration may help to avoid gastric discomfort.

How Supplied:

LUFYLLIN, 200 mg., Tablets: NDC 19-R521-92, bottle of 100; NDC 19-R521-97, bottle of 1000.

LUFYLLIN Elixir: NDC 19-R515-68, pint bottle; NDC 19-R515-69, gallon bottle.

LUFYLLIN Injection: NDC 19-R537-T2, box of 2 x 2 ml. ampuls.

PRUNING TIME

Planted as a seed of social revolution in America in the early 1930's, the clamor for some form of tax-supported, federally-controlled health care program has now become a wild, unflowering vine. Its growth has gone beyond the limits of manageability. It has so many branches trailing off in so many directions that it has overgrown all order and reason. In an effort to stimulate its growth and bring it to flower, a broad-scale attack was launched against the entire health care establishment by media people and politicians about ten years ago. Their major criticisms were — and are — that health care was too expensive, too unavailable, too haphazard and too poor. Under the wise and watchful eyes of assorted bureaucrats, lawyers, elected and appointed government officials, and of honest, impartial, medically-expert, omnipotent journalists, all these deficiencies could be corrected. More care, of a higher quality, could be rendered to more people, more efficiently for less money.

Of course, this is hogwash. Any rational person who has an understanding of the complex problems involved in delivering health care — and who also understands the staggering inefficiency of the bureaucratic process — knows it's hogwash. Yet, on the eve of decision, no one has ever been able to convince the politically responsible people in this nation that it is, patently, hogwash.

We, as individual physicians, and our professional organizations, at every level, have failed to gather and present the evidence in a way that would convince most Americans that their health is being jeopardized by government decree.

Each of us needs to know the actual administrative costs of Medicare, Medicaid, V.A.

medical care, armed forces medical care and all other government-controlled, tax supported health care programs. Then, these costs should be compared with the administrative costs of private-agency care. Also, we need to know how effective these government-controlled health services are in maintaining health and preventing disease, injury, absenteeism, disability and death.

Such information and data are available, and we should have a corps of experts, working full time, digging it out of the bureaucracy's hide-away bookkeeping system.

Once obtained, the evidence — in hard, honest facts and figures — should be given to the people of this country, on a daily or weekly or monthly basis. Since the odds are heavily against the likelihood of the media voluntarily disseminating these reports, they should be publicized through spot announcements on radio, ads in newspapers, by billboard displays and, yes, even by handbills.

Such a direct approach to keeping the public honestly informed about the current cost-effectiveness of existing government-controlled health care programs would cut through the obfuscation designed by the bureaucrats and maintained by the media.

Perhaps, too, such an approach would cut some branches of that tangled vine which, in its wild and crazy growth, is threatening our freedom and our national solvency.

Certainly nothing could be more appropriate as we approach our nation's bicentennial than to resist enslavement and bondage, and, through the medium of pamphlets, handbills and public notices, regain the stature of freedom. *MRJ*

Confidentiality! Can there be any word more important to a patient? Or the loss of which could be more hazardous? This is exactly what faces the public when PSRO is implemented. By the government's own declaration, nationwide computerized print-outs are to be made of all entries in the charts of all patients. At the same time, the government contends that the information will be held confidential and protected. No thinking person can possibly believe this. Such taped information, passed from hospital to hospital and from government agency to government agency, must necessarily pass through the hands and before the eyes of literally thousands of employees from all strata of society having all varieties and degrees of responsibility and persuasion. A break in confidentiality can occur and will occur time and again, place after place. This was proven in the Watergate incidents. It was also proven in the theft of a million dollars worth of narcotics stored in the "security vault" of the New York Police Department. So anyone who assumes that the information can be protected from revelation is simply naive. Now what can be the result? Information in the hands of unethical or mercenary persons could result in blackmail, bribery, divorce, cancellation of insurance, loss of a job, loss of credit rating, public ridicule and unlimited litigation of all types. It should be remembered also that the computer cannot discern fact from fiction, so that all information, true or false, will be recorded on the tapes. Nefarious ones can have a circus with information intercepted — and intercepted it will be, most assuredly. To my mind, this is one of the greatest dangers in the PSRO Program and every effort must be made to have computerization eliminated.



Actually, it is infringement of one's constitutional rights.

In addition to the above, it will soon become apparent that a patient cannot safely, freely or honestly give a proper medical history; to do so may place him, and his family, in jeopardy. Information can be transmitted and transported without the informed consent of the individual. Incriminating information that is false can be inserted, either by mistake or by intent. Already there are commercial computer centers storing patients' profiles that are being sold or exchanged under pretext of developing statistics. Thus instant dossiers become available on almost anybody at anytime. It is then but a short step into the hands of private investigators and personnel bureaus.

Whereas in the past the patients' records had not been officially accessible without the patient's approval, even to other physicians, the government is now about to mount a massive invasion of patient privacy and of the confidentiality of the doctor-patient relationship.

There has never been a time in the history of American medicine in which unity and mutual understanding was needed more. Full communication is needed not only among ourselves, but dialogue must be had with our patients and the public in general. They must be made thoroughly informed concerning the serious drawbacks and disadvantages to them by governmental controls and the serious losses that can result from any decrease in the private, personal medical care they have always had available in this time. History reveals that once privileges have been lost to government, they can rarely be recovered; bureaucracy seldom relinquishes that which it has secured.

Meanwhile, we must provide the best medical care possible in the appropriate medical facility with proper consideration for the cost involved. When this is done, our motives and our efficiency will be unassailable.

J. L. Richardson, M.D.

Management of the Acutely Burned Patient

JACK METCOFF, MD
E. IDE SMITH, MD

Doctor Metcoff advocates the replacement of acute fluid losses in the burned child with less water and less sodium based on measurements of the exudative losses and obligatory edema. Doctor Smith answers in support of the current "formulas" used in burn resuscitation.

Doctor Metcoff: We will talk today about fluid therapy for acute burns. The patient is a 6-year-11-month old Negro boy. He was admitted on the 19th of May with acute flame burns which were said to have occurred a few hours before admission. An estimated 64% of his body surface was involved. I will not go into details of his admission or surgical management because Doctor Ide Smith will do that in a few minutes. That first period of fluid therapy for severe burns (the initial 24-48 hours) has essentially four problems associated with it: (1) estimating the fluid needs of the patient, (2) caring for the burn surface *per se*,

(3) preventing infection, and (4) developing psychological support for the patient. This first period of management requires considerable teamwork.

The second period begins after the first few days and extends into the second week. It is associated with five problems. Fluid therapy is no longer a problem. The outstanding, potential problems are infection, anemia, continued care of the burn surface, psychological support for the patient, and the beginning of rehabilitation. Then, the final period after the burn, the third period, deals with the definitive treatment of the burn surface and its ultimate repair. Of course, these periods cannot be sharply demarcated. They blend into each other. After the initial acute phase, the major emphasis should be on psychological support for the child, rehabilitation of the severely burned patient, and concern about his nutritional status. Doctor Ide Smith will now comment about the initial surgical management.

Doctor Smith: The patient received his initial therapy beginning with the Evans' formula. He had minimal debridement and tetanus prophylaxis. He was given meperidine hydrochloride (Demerol) intravenously for pain, and the burn was treated topically, first with manfenide and then with silver sulfadiazine.

Doctor Metcoff: Were there any major complications during the initial post-burn period?

From the Department of Pediatrics and Pediatric Surgery, The Children's Memorial Hospital, University of Oklahoma Health Sciences Center and The Oklahoma Department of Institutions, Social, and Rehabilitative Services, Oklahoma City, Oklahoma

Doctor Smith: None. I think one point I would like to stress is that philosophically I have looked at the three areas that you mentioned as components of one problem: fluid therapy, psychological support, and prevention of infection. I think it is terribly important to conceive of these not as isolated, but as interrelated problems which are a part of the one major problem.

Doctor Metcuff: I certainly agree that there is no differentiation between these phenomena. They are, indeed, as Doctor Smith has said, completely interrelated. They are presented as separate problems only for emphasis.

This child had a 64% body burn. The efforts of the surgical team were effective and life-saving. Sixty-four percent burns often are fatal, particularly in childhood. The fact that this child survived and did reasonably well should be emphasized. I propose to talk about a certain philosophy dealing with the fluid therapy part of the initial burn treatment. I am going to present a point of view different from that often expressed by members of good surgical services.

I have tried to assess this child's fluid therapy over the first 32 hours. He was a 6-year-11-month old boy. He weighed 19.04 kg at the time of admission. He was 116 cm long, which gave him a surface area of 0.8². I do not know whether he was weighed prior to begin-

A 1944 graduate of Northwestern University Medical School, Jack Metcuff, MD, is presently Professor of Pediatrics, Professor of Biochemistry and Molecular Biology at the University of Oklahoma Health Sciences Center. He is a member of the American Society of Nephrology, the Society of Pediatric Nephrology, the American Society for Clinical Investigation, the American Society for Clinical Nutrition and the American Pediatric Society.

A 1948 graduate of Johns Hopkins University School of Medicine, E. Ide Smith, MD, has been certified by the American Board of Surgery and specializes in pediatric surgery. He is Clinical Assistant Professor of Surgery and Pediatrics at the University of Oklahoma Health Sciences Center. He is a member of the American College of Surgeons, the American Academy of Pediatrics (Surgical Section), the American Pediatric Surgical Association (Founding Member) and the American Burn Association.

ning fluid therapy, that is, without arm board and leg boards and bandages, or whether he was weighed after these were applied. It would be desirable to get an initial weight before the patient is bandaged and hooked up to intravenous infusion equipment, and another weight immediately after these are applied. The second weight is the baseline for repeated weighings. The first weight is the actual weight of the patient.

In the first 32 hours, his total fluid intake was 7,880 ml and he received about 1,100 mEq of sodium and about 149 gm of protein. His urinary output was 2,567 ml. He gained 2.5 kg during this 32-hour period. That weight gain represents edema. The estimated average losses during this period have been measured and reported previously.¹ Based on those data, for his burn he should have received about 5,000 ml of fluid and about 100 mEq of sodium. He received approximately ten times more sodium than I suspect was necessary. His protein requirement, based on his expected exudative losses, should have been about 60 gm. He received 149 gm. I would have anticipated a smaller urine volume for him had he received the amount of fluid calculated as above, but he had a very large fluid intake. Fortunately, his kidneys were able to respond with a larger urinary output. Despite this, he gained 2.5 kg. This edema was the result of fluids leaking through injured capillaries. The "obligatory edema" under the burn surface area occurs promptly, within a few minutes to two hours after the burn. I would estimate that it should have amounted to only about 140 gm. Unless the patient receives too much fluid, further accumulation of extracellular fluid, plasma, or intracellular fluid does not occur. According to recent studies, further subcutaneous edema results from diffusion of excess parenteral fluids.

Where do these figures come from and what do these calculations mean? Figure 1 shows intake and urinary output and weight gain over the 56-hour period of observation. The observed pattern is compared with our calculated estimates. The difference between observed and calculated fluid intake is about 2.5 liters per calculation. The expected urine volume on the same basis would be about 1.5 liters. The only edema would have been the result of the burn, which amounted to about 140 gm.

I would like to explain the physiological reasoning and the direct study observations which form the bases for the calculations re-

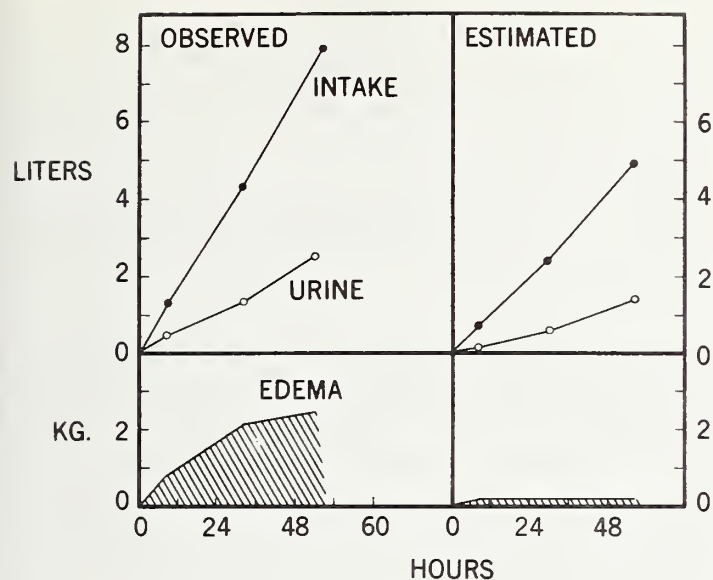


Figure 1: Estimated and observed intake and urinary output: case 1

ferred to. The exudative losses from the burn surface were originally interpolated from studies of blister fluid from burned animals, or in some instances, of blister fluid from human patients. Later, Doctor Artz and his associates of the Brooke Army Hospital applied absorbent dressings to the burned surface of human patients, collected all of the exudative material in the dressings, and analyzed it. Their data for electrolyte values and protein losses in five patients were the first reasonably accurate estimates of burn surface losses. We used exactly the same technique in children. By measuring the surface over which the collection was made, we could relate the losses to 100 sq cm of burn surface. The average skin exudate values for these children in a 24-hour period would be a loss of about 15 ml of water, about 1 mEq of sodium, about 0.1 mEq of potassium, and about 1 mEq of chloride per 100 sq cm of burn surface. For the patient being discussed today, total surface area was 8,000 sq cm. Sixty-four percent or 5,120 sq cm was burned (Note: 10,000 sq cm = 1 sq m). Since 7.3 ml of water are lost per 100 sq cm, 7.3 ml/100 sq cm \times 5,120 sq cm or 374 ml would be the exudative water loss expected from his entire burned surface over a 12-hour period. Burn losses go down slightly in the subsequent 24-hour periods. His exudative water loss in the first eight-hour period was calculated to be in the neighborhood of 300 ml, and this would contain about 20 mEq of sodium.

Doctor Humphrey: What type of topical therapy were the four patients you studied receiving?

Doctor Metcalf: Topical therapy was not used. The urinary output bears little rela-

tionship to the infusate volume during the first 24-hours after the burn. Irrespective of very large fluid infusions in the first 12 hours, it appears that urinary volume tends to be very much smaller. Urine volume gradually increases over the subsequent 12-hour periods, again somewhat independently of fluid intake. There is no direct relationship between urine volume and infusate volume. By 24 hours after the burn, there is an excretion of about 15%-20% of the therapeutic infusate. By 36 hours, this averages about 40% of the infusate; by two days, about 50% of the infusate volume can be excreted as urine.

Several burned children were observed here last year and the urinary volume as a proportion of the intake was calculated. These children received a modified Evans' formula treatment. The urinary output by 48 hours was about 40%-50% of the infusate volume. By three days, it averaged between 50% and 60% of the infusate volume. During the initial period, almost irrespective of the intake, only a very small portion of the infusate is removed in the urine. Why doesn't a large infusate volume "flush the kidneys?" It should if kidney function is completely intact. Then as one increases the infusate volume, the functioning kidney can readily remove the excess fluid.

This is not actually the case in children with severe burns. The urine volume gradually increases over the first 24 hours. For example, on one child, urine output ultimately amounted to about 1 ml a minute per square meter of surface area. On the other hand, during the initial ten hours, she received 2 ml per minute of infusate, but because the urine volume remained low, she then received 3.5 ml per minute infusate over the next ten hours. Urine volume gradually rose. Measurements of renal functions (glomerular filtration rate and renal blood flow) during these periods gave evidence that renal function was impaired in the first 24 hours after the burn and then rapidly rose to normal levels. We have made similar observations in about four or five different studies. Sometimes the takeoff point for improved renal function is about 20 hours, sometimes at about 28 hours, sometimes a little before 20 hours, but the general pattern is the same. Generally, renal functions are reduced, probably as a result of a striking reduction in renal blood flow, during the initial hours following the burn. There is an equivalent decrease in the glomerular filtration rate. From the point of

view of the nephrologist, the lack of urine volume is the result of a reasonably competent capacity for reabsorption of a small filtrate. Water reabsorption by the renal tubule continues even though the urine volume is quite low. The glomerular filtration rate is also low. The low urine volume in the first 12 to 24 hours after the burn depends upon the reduction of glomerular filtration which may be attributed to the decrease in renal blood flow. To attempt to increase urine volume at a time when renal blood flow and glomerular filtration is reduced is fraught with danger, because it is quite likely that the kidney will not be able to respond to that extra load. As a result, the excess water will accumulate. That is edema. The massive edema of burned patients appears to be the result of the discrepancy between the ability to remove the water in the urine, due to reduced renal function, and the large volumes of fluids which are infused.

As an example, observations were made on three children treated by three different types of fluid administration. One received an Evans' formula which contained a large amount of water and salt. The cumulative water balance over a 48-hour period was about 1,400 gm, which represented a 25% increase in body weight. There was a huge positive balance of sodium, about 210 millimoles which was about equivalent of the retention of water. In contrast, another patient received an amount of fluid based upon the estimated losses which had been measured in previous patients. The infusate volume and composition were calculated to apply to the expected requirements. The net positive water balance was small, between 4 to 5 ml, and remained reasonably stable at 48 hours. The sodium balance remained at the baseline throughout and there was no edema in this child.

Calculations for fluid requirements (Table 1) were based on previous studies. I do not use surface area as a reference in these calculations because I think all fluid therapy should be expressed in square meters, because when one is dealing with a burn, one is dealing with the problem of a surface loss. That surface is best expressed in square centimeters. Hence, in order to keep all the units the same, I adjust fluid therapy to square meters.

The urine volume in the first 12-hour period is generally low, amounting to about 110 ml

Table 1
Calculation of Fluid Requirements*

Exudative losses	7.3 ml/100 sq cm burn surface area
Obligatory edema	2.8 ml/100 sq cm burn surface area
Insensible water loss	450 ml per sq m body surface area
Urine	110 ml per sq m body surface area

* first 12 hours.

per sq m provided there is not a very large excess of fluid given. If there is, urine volume may be double or triple this amount, but it can only increase to the extent that the kidney is capable of functioning. During the immediate post-burn period, the kidney cannot easily cope with excess fluid, so even though the urine volume may be increased by volume overload, it is almost never sufficient to prevent the accumulation of water. The urine volume gradually increases, and one would anticipate that the fluid requirements over the first 48 hours would increase. The reason for this is that although insensible water loss remains the same and exudative losses continue at about the same rate, the increased urine volume requires replacement. Hence, fluid therapy should increase during the first 48 hours. In contrast, usually a very large intake is provided in the first 12 hours and then is gradually reduced. It is that large initial intake which I believe accounts for the edema.

Exudative losses generally tend to be small. If the patient has surface application of an agent which prevents exudation, for example silver nitrate or sulfamylon, exudative losses will be lower. With silver nitrate, the exudative losses are about 50% less than without any surface covering. The losses with sulfamylon are probably greater than those with silver nitrate, but less than those without any surface covering. Exudative losses are calculated on the basis of 7.3 ml/100 sq cm of burn surface per 12-hour period. For a child with 60% burn, who has 1 sq m of total body surface, there would be 6,000 sq cm of burn surface: $6,000 \text{ sq cm} \times 7.3 \text{ ml/100 sq cm} = 1,170 \text{ ml}$ of exudative loss. It is quite a simple calculation.

Edema is a little more complicated to calculate. On the basis of studies previously reported, obligatory edema will amount to about 3 ml/100 sq cm of burned area. Skin and subcutaneous tissues are about 75% water. In cases where the edema is so obvious you cannot only see it, but you can pit very deeply by

pressure from your finger, the water content of the skin and subcutaneous tissue has increased by about 10%. That means that instead of 75% water, it is 85% water. With that as a figure for marked edema, I calculated the maximal amount of water edema that would accumulate in the burned area. That number turned out to be about 3 ml/100 sq cm of burned surface. The obligatory edema which occurs initially does not recur. The obligatory edema need be taken into consideration only once, and therefore, is calculated for the first 12 hours only and not for subsequent fluid requirements. So in a child with a 60% burn, 110 ml is lost urine volume, insensible loss would require about 450 ml/per sq m of surface area, and exudative losses would be about 130 ml. The accumulation of edema fluid would be equivalent to 168 ml. All of these losses would total about 1,100 ml. This would satisfy the fluid requirements for 12 hours for a child with a body surface area of 1 sq m who has a 60% burn. The same kind of calculation is applied to the subsequent period to bring into consideration the increasing urine volume.

I have applied this type of calculation to the child under discussion this morning and estimated his losses for the first 12 hours and then adjusted those to the actual periods of observation, which were eight hours, to coincide with nursing shifts. For exudative losses, at the rate of 7.3 ml/100 sq cm of burn surface with 5,120 sq cm of burn surface, 374 ml are required to cover losses for a 12-hour period. Obligatory edema would require 2.8 ml per 100 sq cm \times 5,120 sq cm = 143 ml. Insensible water loss was estimated to be 365 ml, or 450 ml per sq m times a surface area of 0.8 sq m. My estimate of what his urine volume would have been had he received this amount of fluid therapy is that he would have had 88 ml of urine and 970 ml total losses for the 12 hours or 728 ml for eight hours. The calculated fluid would include a gain of 143 gm of obligatory edema fluid. Actually, he received 1,240 ml instead of 728 ml during that eight-hour period, his urinary output was 479 ml instead of 88 ml, and he gained about 0.8 kg of body weight.

The calculation of the electrolytes and proteins required was also based on the previously measured losses. Knowing what the surface loss will be and measuring the concentration and content of electrolytes and proteins in it and in the urine, it is possible to calculate the electrolyte and protein losses per square meter

of body size in a child for a given burn area. In the first 12 hours, such a child would lose about 53 Eq of sodium from the exudate and from the urine. In the next 12-hour period, losses would be similar. The potassium losses tend to be rather small. The protein losses are appreciable, but not as large as are commonly thought. For this child, the protein losses amount to about 30 gm in the first 12 hours and then subsequently stay at about the same level. I estimated this child would have about a 60-61 gm protein loss in his first 52 hours of treatment. He received about three liters of plasma. If it contained 6% protein, he would have received about 180 gm of protein, an amount which was roughly two to three times his expected losses.

I have attempted to make some comparisons between different recommended fluid therapies. The calculated amounts of fluid based upon our actual observations in children for the initial 48 hours represent at least a 20% reduction from the amounts recommended by Evans.

The main problem with fluid therapy in the initial post-burn period derives from the conception that it is necessary to sustain a given arbitrary urine volume, eg, 1 ml/min. Fluid then is infused until the urine volume gradually increases to the arbitrary, pre-determined level. This reasoning is based upon an incorrect premise. There is nothing magic about maintaining a given urine volume during early fluid therapy after a severe burn. Urine volume reflects the kidney's capability to remove water. The provision of large quantities of fluid which exceed the capacity of the kidney to remove the excess is fraught with danger. Not only will edema occur, but there is a very real possibility of producing edema in organs such as the lungs and brain. During the second 24 hours after the burn, the children do tend to become hypotonic and edematous. If hypotonicity and edema are marked, the children may have seizures related to excessive water retention, dilution of the extracellular fluid, and possible edema of the central nervous system. I think this unfortunate sequence of events could be completely prevented by the appropriate administration of fluid.

To summarize, it seems to me that there is no rule of thumb that should be used in the treatment of severely burned children, or for that matter, in any form of parenteral fluid therapy. It is possible to use very simple

arithmetic and calculate the needs of a particular child. The calculation of fluid replacement and maintenance is based upon observed losses in similar situations. It takes only a matter of minutes to calculate requirements. To do so, you need to have the weight and the length of the child. The weight should be obtained before and after his arm boards, tape, and intravenous tubing are applied. These first weights are the essential baseline for reference. His length should be measured initially. Surface area then can be calculated. The estimate of burn surface area is done by using the burn nomograms which provide a reasonably good approximation. Once the percentage of burned surface is estimated, the actual number of square centimeters of burned surface can be calculated. One square meter is equivalent to 10,000 sq cm. So a 60% burn surface in a child with a body surface area of 1 sq m, for example, is equivalent to 6,000 sq cm of burn area. If the exudative losses in 12 hours amount to about 7 ml N/100 sq cm of burn and the burn surface is 6,000 sq cm, then $7 \text{ ml}/100 \text{ sq cm} \times 6,000 \text{ sq cm} = 420 \text{ ml}$ of potential exudative water loss from the burned surface, provided silver nitrate, sulfamydon, or some other agent which may diminish exudative loss has not been used. Urine volume indicates the effectiveness of renal function. Renal function, in turn, is going to depend upon the adequacy of the renal blood flow. Even though one infused volume expanding agents such as plasma and albumin, it does not seem to appreciably change renal blood flow during the first 12 hours following an acute burn. Renal blood flow is sustained, but at a low level, and the plasma seems to be diverted to circulations other than the renal circulation. Urine volume will increase gradually as renal function increases. The quantity of urine excreted in the first 12 hours for a child with 1 sq m of surface area is usually in the neighborhood of 100 ml. In the second 12 hours, it is about double that. In the first 24 hours, therefore, one should anticipate about 300 ml of urine will be excreted per square meter of body surface. Insensible water loss is the result of respiratory and evaporative skin losses. The evaporative skin loss from the non-burned surface continues as well as exudation from the burned area. If the body temperature goes up, the evaporative losses will increase. Generally, about 130 to 450 ml

per sq m of unburned body surface are lost in the 12-hour period.

Taken together, calculated allowances for exudative loss, insensible water loss, and urine volume permit accurate provision of sufficient parenteral fluid to satisfy fluid requirements, yet avoid fluid overload and excessive edema.

Doctor Smith: There are a couple of things that I feel have to be put into perspective. One is mortality and certainly everyone who deals with burns stands on the mortality which he had reported in cases for the world to see. There can be little argument that the mortality from shock has been greatly diminished by a standardized approach to fluids. I would be very concerned if one were to try to get away from these formulas without having a better or an equivalent alternative. There is a difference between the problems which face an investigator in a clinical research center with one burn and the problems which relate to the treatment of ten burns resulting from a school bus accident as they come in the emergency room. Much of the approach that is pertinent and lifesaving in one does not apply with the other.

The other point which I think is fairly critical, and I think perhaps Doctor Metcuff may have passed over somewhat, is whether or not (and we do not know this quite frankly) the kidney is intrinsically troubled and altered by the burn or whether the kidney is normal. Is the fall in glomerular filtration rate a result of low plasma flow or low cardiac output, and is this the responsible party for the kidney dysfunction? The old concept that at the time of an operation there is an obligatory kidney depression is probably under serious question. If one preloads an individual prior to an operation to a point where there is no diminution in extracellular volume during the operation, the individual can come out of that operation with a kidney that functions if not normally, at least very close to normal. Recent experimental work on burn injury suggests that the critical 30 minutes to 60 minutes after the burn may be the most critical period for fluid shifts. If fluid needs of the individual are rapidly met, will the kidneys function normally? This is the critical question. There is no doubt that if one loads the burn victim with an unphysiological amount of fluid the cardiac output can be raised to normal far more rapidly than it can be otherwise. The question is, "Is the price which one pays to do this too high a price and

Table 2
Topical Therapy of Burns in Children : Neurological Complications²

Age	Agent*	Burn Surface Area (%)	Manifestation	Post-burn Day	Cause
8 mo	M	20	Seizure	2	Hypernatremia
4 yr	M	15	Coma	2	Electrolytic; hypokalemia
6 yr	F	40	Seizure-coma	83	Sepsis, urinary tract disease
6 yr	F	54	Coma	38	Unknown
1 yr	M	14	Seizure	2	Hypernatremia
2 yr	M	10	Seizure	Burn day	Previous seizures
3 yr	M	20	Seizure	5	Mental retardation with seizures
3 yr	F	25	Seizure	42	Unknown (?sepsis)
2 yr	F	24	Seizure	7	Unknown (hypertension)
5 yr	M	30	Coma	3	Hypernatremia, mental retardation

* M, marfenide; F, furazolium.

too harmful a price in terms of the overall economy of the individual?"

The critical organ area really is not the glomerulus, but the cells which have been injured in the burned area. What you really are concerned with is the maintenance of the peripheral circulation and nutrition of this area as well as all areas of the body during the critical phase. There is sludging of the capillary flow in the burned area. There is also an undeniable capillary lesion which leads to the leakage of protein for the first 12 to 24 hours. The damaged capillaries are going to leak water and electrolytes, but the question that still has to be asked is what constitutes the optimal situation for these cells in what is essentially an unphysiological injury? There is as great an interest in therapy with enormous quantities of sodium without water as there is in considerably less sodium and more water. The goal which we seek is the maintenance of optimal peripheral circulation in the burn area, and it may well take a very unphysiological solution in both senses of the word to achieve this. At the periphery of a burn are a number of cells which are on the borderline of death or of survival. I think it is the nutrition in this area which we are critically concerned with in terms of our maintenance of the circulation in the area of the burn.

Are there any questions or comments?

Doctor Krober: One suggestion was that sometimes the neurologic dysfunctions you see in the burn patient might be related to fluid overload. I am not sure of your reaction to that

hypothesis, or do you think that some other aspect is more important?

Doctor Smith: In our own experience, there has been more neurological dysfunction from hyperosmolarity caused by inadequate fluid than there has been from hypoosmolarity. This was true in the 229 cases which we reported from Kansas City's Children's Mercy Hospital.

Doctor Humphrey: Ide, what about the renal clearance rates during fluid delivery?

Doctor Smith: They are rapidly decreased within a period I believe of two or three hours, Ben. These neurological complications are shown in Table 2. You will notice that of those occurring along with hypernatremia (sodium level of over 145/mg%), there was probably inadequate fluid therapy, or at least it is our assumption that this was true. There was a hypokalemia on the 15th post-burn day. These babies were generally not treated with lactated ringers; they were more often treated with maintenance fluids which, in the face of vomiting, were inadequate. Our problems were due to iatrogenic inactivity more than to iatrogenic overactivity. □

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Extrahepatic Complications of Viral Hepatitis

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Extrahepatic complications of hepatitis are not rare. Evidence is accumulating that immune complexes involving hepatitis antigen (HBAg) play a role in periarteritis, anemia, and polyarthritis.

INTRODUCTION

Viral hepatitis is a common systemic disease predominantly affecting the liver. There are two epidemiologically distinct but clinically similar forms: Infectious hepatitis (hepatitis A) and serum hepatitis (hepatitis B), both of which are characterized by inflammation and necrosis of hepatic cells. It is now clear that these two forms are immunologically distinct and are caused by different viruses, respectively A and B. Blumberg and co-workers first reported discovery of a circulating antigen in hepatitis which was designated "Australia antigen," then "hepatitis-associated-antigen" (HAA). More current usage suggests that the symbol "HBAg" will replace the earlier terms. HBAg appears to represent at least a portion of

the infective virus particle and has become a common marker of hepatitis B in that it can be demonstrated in 50 to 98 per cent of patients infected with hepatitis B. Recent investigation suggests that HBAg may contain two or more immunologically separate types. The implication of this observation is not yet clear but raises the possibility that several viruses may cause hepatitis. Several particles in plasma are intimately associated with HBAg. Dane in 1970 described a particle of approximately 43 nm which carried HBAg. This has been designated the Dane particle.¹

Hepatitis produces a spectrum of manifestations ranging from symptomatic infection to fulminant disease leading to death in a few days. The course of infectious hepatitis has been well described many times and need not be reviewed here. After the onset of jaundice, the clinical course of hepatitis A and hepatitis B are quite similar except that the latter tends to be more severe and hepatic complications such as chronic aggressive hepatitis are more common. In general, viral hepatitis has a good prognosis with a mortality rate of 0.04 to 0.08 per cent among formerly healthy individuals. However, if the disease progresses to chronic aggressive hepatitis or acute fulminant hepatitis, hepatic failure may result in death. The outcome for patients in hepatic failure is greatly influenced by associated complications which include: hemorrhagic diathesis, second-

ary infection (such as pneumonia or septicemia), hypoglycemia, hypokalemia, acid-base disturbances, cardiovascular disturbances, fluid accumulation, renal failure and respiratory failure. These complications occur because of impaired function of hepatocytes and other liver cells which have been damaged by the inflammatory process.

Another group of complications is sometimes seen in hepatitis which is not so directly related to impaired function of liver cells. It is the purpose of this paper to discuss some of the common extra-hepatic complications of hepatitis reported in recent publications.

EXTRA-HEPATIC MANIFESTATIONS OF VIRAL HEPATITIS

Polyarteritis Nodosa

The association of liver derangements and polyarteritis nodosa was described in 1954 by Mowrey and Lundberg.² They reviewed 200 literature cases of polyarteritis and 230 autopsy protocols from the Armed Forces Institute of Pathology. They were interested in hepatic complications of polyarteritis and many of the cases they reported were not associated with infectious hepatitis. On the contrary most of the changes were hepatic complications caused by arteritis such as rupture of an artery or occlusion with hepatic infarction. The first association between polyarteritis nodosa and HBAG was described in 1970 by Gocke and coworkers.³ In a study of 11 patients with biopsy-proven polyarteritis nodosa, four had concomitant HBAG in serum. Each case presented with fever of obscure origin accompanied by polyarthralgia, myalgia, rash and urticaria. Evidence of mild hepatic damage was present but hepatic dysfunction was not the primary problem. Further studies showed: (1) The antigen was not found in 49 patients with systemic lupus erythematosus, rheumatoid arthritis, or other "connective tissue disorders." (2) HBAG was not found in 153 patients tested randomly; and finally in a prospective study of post-transfusion hepatitis, HBAG was present in only one percent. Thus, although not all cases of polyarteritis nodosa were associated with HBAG, its presence in four of eleven patients was much higher than could be accounted for by chance. Three of the four patients also had circulating immune complexes consisting of HBAG plus immunoglobulin and one patient was found to have deposition of

HBAG, IGM and complement in blood vessel walls. These observations raise the possibility that some cases of polyarteritis arise as an immunologic complication of hepatitis B.

Further studies have linked necrotizing angiitis with HBAG. Koff *et al*⁴ suggested that necrotizing angiitis associated with methamphetamine abuse may in reality be due to hepatitis B. These authors suggest that testing for HBAG may be warranted in patients with necrotizing angiitis regardless of whether or not a history of methamphetamine abuse can be obtained.

Cardiac Manifestations

Adler and Lyon⁵ in 1947 found a 7% incidence of abnormal cardiac signs and symptoms in a group of patients with icteric viral hepatitis. Angina, palpitations, tachycardia, arrhythmias and dyspnea were observed along with electrocardiographic abnormalities which included P-wave, T-wave, and S-T segment changes.

A retrospective study of thirty consecutive autopsies of patients who died with acute viral hepatitis showed clinical evidence of cardiac disease manifested by prolonged hypotension, progressive cardiomegaly, pulmonary edema and sudden death.⁶ EKG abnormalities included left axis deviation, T-wave abnormalities, and arrhythmias. Pathologic findings revealed widespread petechial hemorrhage, infiltration with lymphocytes, fatty degeneration, flabby dilated ventricles and edema of the

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subendocardial connective tissue. Petechial hemorrhage was the most common abnormality and frequently involved the epicardial and subendocardial surfaces of the heart as well as the interventricular septum. Lymphocytic infiltration of the myocardium in fatal cases has been attributed to a direct viral effect.⁷ Lucke⁸ found that fatality was most commonly linked to hemorrhage into the interventricular septum.

Cardiac manifestations have been further delineated in a case report by Kontaxis *et al*⁹ of a nine-year-old girl with complete heart block following infectious hepatitis. The patient presented with syncopal attacks. She had been in good health until one month previously when she had become jaundiced because of infectious hepatitis.

Elevated serum bilirubin is thought by some to be important in explaining these cardiac abnormalities. Wakin and coworkers have shown that injected bile salts cause tachycardia, asystole, severe hypotension, heart failure and death in animals.¹⁰ At present cardiac abnormalities are not obviously more common in one or the other type of hepatitis.

Anemia

Conrad and coworkers found contrary to prior opinion that anemia occurred frequently in hepatitis patients although it nearly always corrected spontaneously during convalescence.¹¹ This anemia was associated with increased hemolysis. It has been suggested that the hemolysis might be associated with antigen-antibody reactions on red cell surfaces.

The association of viral hepatitis and aplastic anemia was first described by Lorenz and

Quaiser in 1955.¹² It may occur one week to several months after the onset of acute viral hepatitis. The incidence seems to be higher in males, especially under age 20 years. There may be pancytopenia. In either case, the prognosis is very grave.

It has been suggested that hepatitis virus might induce chromosomal damage in the hematopoietic system with subsequent stem cell failure. In some cases liver failure might result in decreased detoxification of drugs with resultant harmful effects.¹² Deller and coworkers suggested that the virus could induce an autoimmune reaction with resultant bone marrow failure.¹³ This latter possibility is perhaps supported by the occasional response to corticosteroid therapy.

Bodenbender¹⁴ reported a 12-year-old girl who developed aplastic anemia nine months after apparent recovery from viral hepatitis. Her clinical course was complicated by menorrhagia and lack of bone marrow remission in spite of multiple transfusions and corticosteroid therapy. She died with bilateral hemorrhagic pneumonia and gastric hemorrhage.

Arthritis

Arthralgias and arthritis associated with hepatitis have been observed for many years.¹⁵ The arthritis usually involves multiple joints and produces effusions characterized by several hundred to several thousands of cells which are almost all mononuclear.

The joint involvement is symmetrical and may involve the peripheral small joints as well as the weight bearing joints. Occasionally the distribution resembles that of rheumatoid arthritis. Rheumatoid factor, however, is absent.

Interestingly, the arthritis occurs during the prodromal periods, resolving spontaneously with the advent of jaundice. It frequently is accompanied by skin rash and may precede clinical hepatitis by as long as one month.

Onion and coworkers found that the arthritis was accompanied by a fall in serum complement and the appearance of HBAG in serum. As jaundice appeared complement returned to normal and HBAG disappeared as antibody to HBAG appeared.¹⁶ These investigators also demonstrated HBAG in synovial fluid and suggested that the arthritis might be the result of circulating antigen-antibody complexes. Permanent joint changes have not been described.

TABLE 1

ENTITY	DATE	INVESTIGATOR
Polyarteritis nodosa with association of viral hepatitis	1954	Lundberg
Polyarteritis nodosa in association with HAA	1970	Gocke
Necrotizing angiitis with Hepatitis B	1973	Koff
Cardiac involvement in viral hepatitis	1947	Adler and Lyon
Complete heart block in infectious hepatitis	1971	Kortaxis
Urticaria in viral hepatitis	1972	Lorenz & Quaiser
Arthritis in viral hepatitis	1843	Graves
Thrombophlebitis	1971	Green

OTHER EXTRA-HEPATIC MANIFESTATIONS OF
ACUTE VIRAL HEPATITIS

Urticaria associated with viral hepatitis may develop in either the prodromal or icteric phase of the disease.¹⁷ Other dermatologic signs include maculo-papular or erythematous lesions, purpura, and scarlatiniform rashes. It is not surprising that the mechanism for these has been thought to be allergic in nature. It has been suggested that an antigen is released from the liver as a result of the viral inflammation with resultant adsorption of antigen-antibody complex onto mast cells causing subsequent histamine release and urticaria.¹⁸

Glomerulitis and thrombophlebitis have also been associated with viral hepatitis. Thrombophlebitis recently reported in a previously healthy young male who subsequently developed jaundice and positive HBAg suggests that viral hepatitis be considered in patients with unexplained thrombophlebitis.¹⁹

CONCLUSION

Advancing knowledge and techniques have permitted more precise diagnosis of viral hepatitis. Not only is it now possible to differentiate hepatitis A and hepatitis B by relatively precise and reproducible laboratory studies but this advance has increased our understanding of hepatic complications such as progressive hepatitis. A number of interesting non-hepatic complications have been described and should be watched for. Although the mechanisms for many of these complications have not been elucidated, there is increasing evidence that antigen-antibody complexes may be responsible. Indeed, Millman and coworkers have demonstrated circulating complexes of HBAg and antibody in hepatitis.²⁰ The occurrence of such "collagen disorders" as polyarteritis nodosa as a possible complication of hepatitis strengthens this hypothesis. It is not beyond

possibility that the actual hepatocyte damage might in reality occur as a result of these immunologic phenomena rather than from multiplication of viral particles.

Addendum:

Since submission of the manuscript a paper further clarifying nomenclature for hepatitis B antigen has appeared. The recognized designation for HGAg is now HB_sAg to indicate that the antigen is a surface antigen on the Dave particle (see Jour. Infect. Dis. 130:92, 1974.) □

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Lincoln Plaza Forum—Oklahoma City

A combined meeting of the Oklahoma State Medical Association, the Oklahoma City Clinical Society and the Oklahoma Academy of Family Physicians.

PLAN TO ATTEND

THE UNIVERSITY OF OKLAHOMA
COLLEGE OF MEDICINE

WEEKLY AFTERNOON OF CONTINUING EDUCATION

EVERY WEDNESDAY

January 1st, 1975 through May 28th, 1975

Developed by
The Department of Medicine
Office of Continuing Medical Education for Physicians
University of Oklahoma Health Sciences Center

Registration fee: \$30.00 per semester

SECOND SEMESTER SCHEDULE

TIME—CONFERENCE—LOCATION

- 12:00 to 1:00 P.M. — Medical Grand Rounds—East
Lecture Hall — Basic Science Building
- 1:30 to 2:30 P.M. — Pulmonary Disease Confer-
ence — C007 Everett Hospital
- 1:30 to 2:30 P.M. — Hematology-Oncology Confer-
ence — A001 Everett Hospital
- 1:30 to 2:30 P.M. — Gastroenterology Conference
— C002 Everett Hospital
- 2:45 to 3:45 P.M. — Pulmonary Problem Case Con-
ference — C007 Everett Hospital
- 4:00 to 5:00 P.M. — Cardiology Conference —
C007 Everett Hospital
- 4:00 to 5:00 P.M. — Infectious Disease Conference
— C002 Everett Hospital
- 4:00 to 5:00 P.M. — Renal Conference — A27 V.A.
Hospital

This program is acceptable for Category I credit to-
ward the Physician's Recognition Award of the
American Medical Association and the American
Academy of Family Practice on an hour for hour
basis.

IMPORTANT INFORMATION: This is a
Schedule V substance by Federal law; diphenoxylate
HCl is chemically related to meperidine
case of overdose or individual hypersensi-
tivity, reactions similar to those after meperidine
or morphine overdose may occur; the
is similar to that for meperidine or mor-
phine intoxication (prolonged and careful moni-
toring). Respiratory depression may recur
of an initial response to Nalline® (naloxone
HCl) or may be evidenced as late as 30
after ingestion. LOMOTIL IS NOT AN AN-
TI-EMETIC DRUG AND DOSAGE RECOMMEN-
DATIONS SHOULD BE STRICTLY ADHERED TO,
ESPECIALLY IN CHILDREN. THIS MEDICATION
SHOULD BE KEPT OUT OF REACH OF
CHILDREN.

Indications: Lomotil is effective as adjunct
therapy in the management of diarrhea.

Contraindications: In children less than 2
years of age, due to the decreased safety margin in young
groups, and in patients who are jaundiced or
sensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children
because of variable response, and with extreme
caution in patients with cirrhosis and other
hepatic disease or abnormal liver function
because of possible hepatic coma. Diphenoxylate
HCl may potentiate the action of barbiturates,
sedatives and alcohol. In theory, the combination
with monoamine oxidase inhibitors could produce
hypertensive crisis.

Usage in pregnancy: Weigh the potential
against possible risks before using during preg-
nancy, lactation or in women of childbearing age.
Diphenoxylate HCl and atropine are secreted in
breast milk of nursing mothers.

Precautions: Addiction (dependency) to di-
phenoxylate HCl is theoretically possible at high doses
not exceed recommended dosages. Administer with
caution to patients receiving addicting drugs
known to be addiction prone or having a history of
drug abuse. The subtherapeutic amount of atropine
added to discourage deliberate overdosage should
observe contraindications, warnings and precautions
for atropine; use with caution in children since
of atropinism may occur even with the recommended
dosage.

Adverse reactions: Atropine effects include
flushing of skin and mucous membranes, flushing and
retention. Other side effects with Lomotil include
nausea, sedation, vomiting, swelling of
abdominal discomfort, respiratory depression,
numbness of the extremities, headache, dizziness,
sweating, malaise, drowsiness, coma, lethargy,
restlessness, euphoria, pruritus, angioedema,
giant urticaria and paralytic ileus.

Dosage and administration: Lomotil is con-
dicated in children less than 2 years old.
Lomotil liquid for children 2 to 12 years of age:
ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 12
years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml.
times daily; adults, two tablets (5 mg.) t.i.d.
or two tablets (5 mg.) q.i.d. or two regular tea-
spoons (10 ml., 5 mg.) q.i.d. Maintenance dosage
may be as low as one fourth of the initial dosage.
Monitor and adjust dosage as soon as initial
dosage are controlled.

Overdosage: Keep the medication out of
reach of children since accidental overdosage is
severe, even fatal, respiratory depression
overdosage include flushing, lethargy or
potent reflexes, nystagmus, pinpoint pupils,
cardiac and respiratory depression which
12 to 30 hours after overdose. Evacuate stomach
lavage, establish a patent airway and, if neces-
sary, assist respiration mechanically. Use of an
antagonist in severe respiratory depression
should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate
HCl with 0.025 mg. of atropine sulfate.
mg. of diphenoxylate HCl and 0.025 mg. of atropine
sulfate per 5 ml. A plastic dropper calibrated in
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News From The Oklahoma State Department of Health

OUTPATIENT CARE FOR TUBERCULOSIS

The prevention and control of tuberculosis in the United States has undergone significant change in the last ten years. In the following statement Doctor Richard M. Burke discusses changing thoughts on the communicability of tuberculosis, and the effects thereof upon current prevention and control recommendations.

"The Madras, India tuberculosis treatment studies (1959) demonstrated that the results were the same whether the patient was treated in a hospital or at home. Further, the incidence of household TB infection was the same in both groups.¹ By 1965 it was generally agreed that isolation was outmoded and the risk of infecting others after effective TB chemotherapy begun is negligible.

"Today there continue to be many TB patients packed off to hospitals solely because of the contagion factor. The danger of the patient transmitting infection is sharply reduced after a few weeks on chemotherapy. At the same time the household associates and other close contacts are placed on TB preventive treatment.² Hospitalization or some type of institutional care of the patient is sometimes needed but it is usually for associated non-tuberculosis conditions and not tuberculosis.³

"Our local health departments have the necessary diagnostic, treatment and consultation services available to handle TB outpatient care." □

1. Andrews, R.H., Devodatta, S. Fox, et al., Prevalence of Tuberculosis among close family contacts of tuberculosis patients in South India and influence of segregation of the patient on early attack rate, *WHO* 23:463-510, 1960.

2. Tuberculosis Care: When and Where? Reichman, L.B., *Ann. Int. Med.*, 80:402, 1974.

3. Guidelines for prevention of TB Transmission in Hospitals: Public Health Service Center for Disease Control, Atlanta, Georgia, Sept. 1974.

COMMUNICABLE DISEASES IN OKLAHOMA FOR DECEMBER, 1974

DISEASE	December 1974	December 1973	November 1974	Total To Date 1974	1973
Amebiasis	2	2	3	29	31
Brucellosis	2	1	2	13	6
Chickenpox	161	14	129	1167	1348
Encephalitis, Infectious	3	—	4	58	101
Gonorrhea (Use Form ODH-228)	1109	641	970	11494	10636
Hepatitis, A, B, Unspecified	49	87	117	999	1140
Leptospirosis	—	—	1	2	—
Malaria	—	—	—	6	3
Meningococcal Infections	1	3	2	19	37
Meningitis, Aseptic	2	4	5	65	107
Mumps	12	44	24	417	512
Rabies in Animals	10	13	13	165	168
Rheumatic Fever	—	—	—	12	16
Rocky Mountain Spotted Fever	4	1	6	70	77
Rubella	—	4	8	66	186
Rubella, Congenital Syndrome	—	—	—	1	—
Rubeola	1	1	—	30	62
Salmonellosis	13	28	18	268	290
Shigellosis	17	18	24	191	204
Syphilis, Infectious (Use Form ODH-228)	19	14	12	152	174
Tetanus	—	—	2	3	4
Tuberculosis, New Active	12	49	18	283	350
Tularemia	—	—	—	18	23
Typhoid Fever	—	—	—	2	2
Whooping Cough	1	2	3	20	23

Medical Summit Features Entertainment and Education

Preliminary plans for Oklahoma Medical Summit '75, the combined annual meeting of the OSMA, Oklahoma City Clinical Society and Oklahoma Academy of Family Physicians, will offer physicians the best in scientific medical programming and entertainment.

Nearly 60 hours of continued medical education for physicians will be available. All lectures and demonstrations are credited by the American Medical Association and the American Academy of Family Physicians. In addition, nearly 100 scientific and pharmaceutical exhibits will be available for viewing.

Oklahoma Medical Summit '75 will be held Thursday through Saturday, April 24th-26th, in Oklahoma City's Lincoln Plaza Hotel. All scientific sections, exhibits and business meetings will be in the new Lincoln Plaza Forum Building.

Although registration will not begin until early Thursday morning, the first official function will take place Wednesday evening. The Early Bird Party is designed to get Summit '75 off to a festive start. The party will begin with a cocktail reception in the Congress Room of the Lincoln Forum Building. It will then adjourn for dinner and a play in Oklahoma City's new Lincoln Plaza Playhouse Dinner Theater. The star for the evening's play will be either Mickey Rooney or Van Johnson, with the exact name of the play and the star to be announced later. The playhouse has been reserved in its entirety for persons attending Summit '75.

Thursday morning's scientific program will begin with a section on immunology being sponsored by the Oklahoma Society of Internal Medicine and The American College of Physicians. At the same time the Oklahoma Academy of Family Physicians will conduct their annual business meeting for members.

The Oklahoma Section of the American College of Obstetricians and Gynecologists is sponsoring a half-day program Thursday morning.

The first of the Summit noon luncheons will be held Thursday. Luncheon speaker will be Herbert L. Holden, MD, President of the American Academy of Family Physicians.

The afternoon will be devoted to a section on allergy sponsored by the Oklahoma Allergy Society, and a symposium on the management of burns being sponsored by the Oklahoma Surgical Association.

Sheldon B. Koronas, MD, Professor of Pediatrics at the University of Tennessee College of Medicine, will be the guest speaker at a section on pediatrics.

Thursday evening's social function will be a double-header. For the men and those wives who wish to attend, there will be a Keg and Oyster Party featuring delightful delicacies from the briney deep and cooling brew. However, for those with a more refined pallet, immediately next door will be a Wine and Cheese Tasting Party. All registrants are invited to attend both functions.

On Friday there will be a full day symposium on cancer sponsored by the State and County Chapters of the American Cancer Society. Preliminary plans call for the Friday morning session to concentrate on surgical intervention in cancer, while the afternoon will take up radiological and chemical intervention in cancer.

A special Superstar Session will be held Friday morning, featuring two outstanding speakers. The first is Phil Thorek, MD, one of the most sought after physician speakers in the United States today. The second speaker on the program will be the new provost of the Oklahoma University Health Sciences Center, William G. Thurman, MD, formerly Dean of the Tulane University School of Medicine.

Two other half-day sessions will be scheduled Friday morning, one by the Oklahoma Society of Pathology, and another by the Oklahoma Branch of the American Psychiatric Association.

The luncheon speaker for Friday noon will

be Phil Thorek, MD, Director of Medical Education for the American Hospital of Chicago.

The Oklahoma City Academy of Ophthalmology and Otolaryngology is sponsoring a full day of scientific program for its members. The morning will be devoted to ENT problems, and the afternoon to ophthalmology.

New concepts in the management of myocardial infarction will be the subject of a half-day program Friday afternoon sponsored by the Oklahoma Heart Association.

Friday evening will offer an opportunity for all physicians to honor the outgoing and incoming presidents of the three sponsoring organizations for Oklahoma Medical Summit: The OSMA, Oklahoma Academy of Family Physicians, and Oklahoma City Clinical Society. The Presidential Inaugural Dinner-Dance will begin with a cocktail reception in the Congress Room at 6:00 p.m. followed by dinner in the Lincoln Plaza Playhouse at 7:00 p.m. (The play will not be offered on this evening.)

A gourmet menu has been arranged and the "official ceremonies" of the evening will be brief. At 8:30 p.m. dance music will be furnished by the Forrest Wasson Orchestra.

Saturday morning will start with a half-day session on hyperlipodemia sponsored by the Oklahoma Medical Research Foundation. At the same time half-day programs will also be offered for urology, anesthesiology, and, of interest to all physicians, a half-day program planned by the Oklahoma Arthritis Foundation.

Saturday's luncheon speaker will be Malcolm C. Todd, MD, President of the American Medical Association.

A special program on the socioeconomical aspects of medicine is planned for Saturday afternoon. Guest speakers will include officials, both elected and appointed, of the United States Government. Henry Simmons, MD, currently the Director of the Professional Standards Review Office of HEW will be one of the guest speakers.

Oklahoma Medical Summit '75 has arranged for a public speaking training program to be conducted on Thursday and Friday, April 24th and 25th, by the Smith, Kline and French Speaker's Training Team.

Attendance at the Speaker's Training Program is limited to 40 persons. Registration will be taken on a first come first served basis.

Physician-participants in the program will learn the principles of effective speech compos-

ition and delivery, manuscript speaking, extemporaneous speaking, the use of visual aids, and how to conduct question and answer sessions. The seminar is two full days in length and follows a workshop format featuring alternate lecture and small group practice sessions.

All materials will be furnished. Although there is no registration fee, advance registration is required and limited.

General registration for the entire meeting will be located in the lobby of the Lincoln Plaza Forum Building at 4545 Lincoln Boulevard in Oklahoma City. It will be open from 7:30 a.m. until 5:00 p.m. each day. Admission to all scientific sections, exhibits, and business meetings is by badge only, available in the registration area. □

Legislative Program Set For Doctors' Wives

A Legislative Orientation Program for Doctors' Wives is being sponsored by the OSMA's Legislative Committee. David Bickham, Associate Executive Director of the OSMA, is organizing the one-day program for March 5th.

All physicians' wives are invited to attend the orientation. It will begin at 9:00 a.m. on that date in the Supreme Court Chambers located on the second floor of the State Capitol Building.

The tentative program includes welcoming remarks by Governor David Boren. The governor's talk will be followed by an explanation of the legislative process and a description of how Oklahoma laws are made.

A panel will be available to discuss legislation. It will include Representatives Hannah Atkins and David Craighead and Senators Ernest Martin and Lee Cate.

An opportunity to attend a public hearing on some bill of medical interest will be made available at about 11:00 a.m. in the morning. Lunch will be served at 12 noon in the Faculty House. Luncheon speaker will be Thomas Lynn, MD, Acting Dean of the O. U. College of Medicine.

The afternoon will be devoted to scheduled tours of the Oklahoma University Health Sciences Center.

All physicians' wives are invited to attend the meeting. Additional information will be sent to physicians' homes as soon as the program is finalized. □



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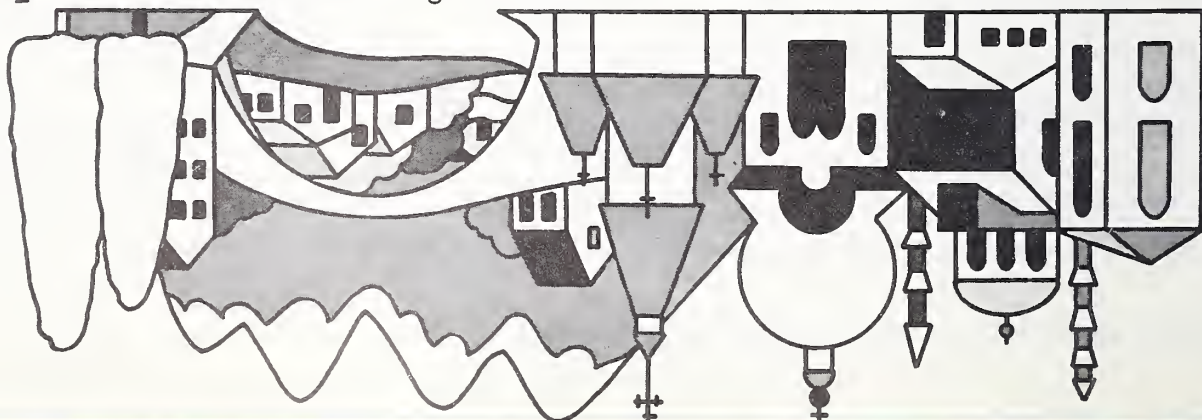
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Another Non-Regimented INTRAV Deluxe Adventure



Balkan Adventure Calls Members of OSMA

An exclusive two-week charter holiday to Eastern Europe and the Balkans is awaiting OSMA physician-members. Cities to be visited include Bucharest, Romania; Istanbul, Turkey; Dubrovnik, Yugoslavia; with a side trip available to Kiev, Russia.

Departure from Oklahoma City is scheduled for July 19th, and the cost, which includes direct flights via chartered jets, accommodations at the very finest hotels, full American breakfasts and gourmet dinners at a choice of the finest restaurants, is only \$1,128.

Arrangements for the trip have been made by INTRAV, a company that has spent years developing deluxe personalized vacations at charter cost savings. INTRAV has sponsored a number of trips for the OSMA and has received the highest praise by persons on the various trips.

Both the OSMA and INTRAV point out that the Balkan Adventure is not a tour, it is a non-regimented holiday designed to give the traveler a maximum amount of free time in each city.

Even though the trip is non-regimented, a travel director and five hosts are available to assist travelers in each city. Optional sight-seeing tours are available each day for those persons wishing to go on them.

The adventure begins when travelers board a chartered World Airways DC-8 jet in Oklahoma City on July 19th. The jet features stretch-out extra comfort seating, first-class meals, complimentary champagne and cocktails, and direct no-change flight to Bucharest.

Bucharest is Romania's 500-year-old capitol. Its broad, tree-lined boulevards, city lakes and well kept parks charm the most traveled visitor. There is always a feeling of anticipation just knowing you are behind the Iron Curtain, yet the place is friendly and easy going.

This part of Europe was the source of many superstitions. One of the best known of which is the vampire. Don't miss the brooding castle of Count Dracula in the nearby countryside of Transylvania.

Although Bucharest is a major center for opera, ballet and symphony, visitors will also find an ample supply of night life, from elegant clubs to cafe's with gypsy violins and lively dancing.

An optional side trip to Kiev, Russia, is available from Bucharest.



An excursion into the lush countryside of Bucharest, Romania, passing small neat houses and the brooding castle of Count Dracula (above), is one of many memorable experiences members of the OSMA will have on their exclusive two-week Balkan Adventure departing in July.

Second stop on the trip is Istanbul, due to its frenzy, a remarkable contrast to placid Bucharest. Golden domes and minarets dot the horizon. This is a city of intrigue. Here is the fabled Blue Mosque of Sultan Ahmed and Sancta Sophia built by Constantine in 325 A. D.

Topkapi Museum in Istanbul features a priceless collection of jewels, ceramics and religious relics. In the Grand Bazaar shops bulge with trinkets and treasures. Copper and brass lamps, kettles and pitchers, Bursa silks, leathers, and Oriental rugs create a flowing sensation of colors and contrasts.

Night clubs feature belly dancers and Turkish folk dancing. The national dish, shish-kabob, should be tried with a glass of good Turkish beer. Optional side trips are available to Izmar and the ancient ruins of Ephesus.

Last stop on the trip is the calm and ancient walled city of Dubrovnik, Yugoslavia, perched on a rocky peninsula overlooking the Adriatic Sea. Residents of the city take great pride in their churches, monestaries, art galleries, museums and hundreds of apartment houses that are physical reminiscences of the medieval past.

For an unusual dining experience, how about dinner in a Benedictine Abbey on a nearby island?

Shoppers in Dubrovnik will find wonderful

buys in pigskin luggage, filigree jewelry, embroidered blouses and dyed wool rugs.

Yugoslavians are friendly, gregarious people who enjoy life in this historic and dazzling seaside resort area. It will be a perfect climax to your Balkan adventure.

For further information or to make reservations for the trip, please contact the Oklahoma State Medical Association at 601 Northwest Expressway, Oklahoma City, Oklahoma 73118, today. Space is strictly limited. □

Department of Medicine Open House Set at Health Sciences Center

Tours of its facilities and a talk by a nationally-known rheumatologist will be highlights Thursday, February 27th, when the Department of Medicine at the University of Oklahoma Health Sciences Center holds a day-long open house.

Included in the day's activities will be the William K. Ishmael Lectureship honoring the local physician, a reception and dinner that night in his honor, tours of the Department of

Medicine facilities and dedication of the department's newly opened library.

Governor Boren has been asked to speak briefly at the dinner along with newly named HSC provost Doctor William G. Thurman, currently dean of the Tulane College of Medicine, New Orleans, Louisiana.

Most of the program for the 7:30 p.m. dinner at the Skirvin Hotel will be vignettes by friends and colleagues of Doctor Ishmael. A reception will be held at 6:30 p.m. and both the reception and dinner are by invitation only.

The open house will begin at 10 a.m. and tours will be formed continuously in the Everett Building lobby until 3 p.m. Dedication of the Masters in Medicine Library, Room 1041, Everett Building, will be at 3:30 p.m. The library will be dedicated in honor of Doctors Robert Bayley, John Colmore and Julian Bahr, all deceased faculty members of the Department of Medicine.

The first William K. Ishmael Lectureship will be at 4 p.m. in the East Lecture Hall of the HSC Basic Sciences Building. The first lecture will be given by Doctor Ishmael himself on "The History of Rheumatology." An anonymous \$25,000 gift was given to the department recently to support the annual lectureship. □

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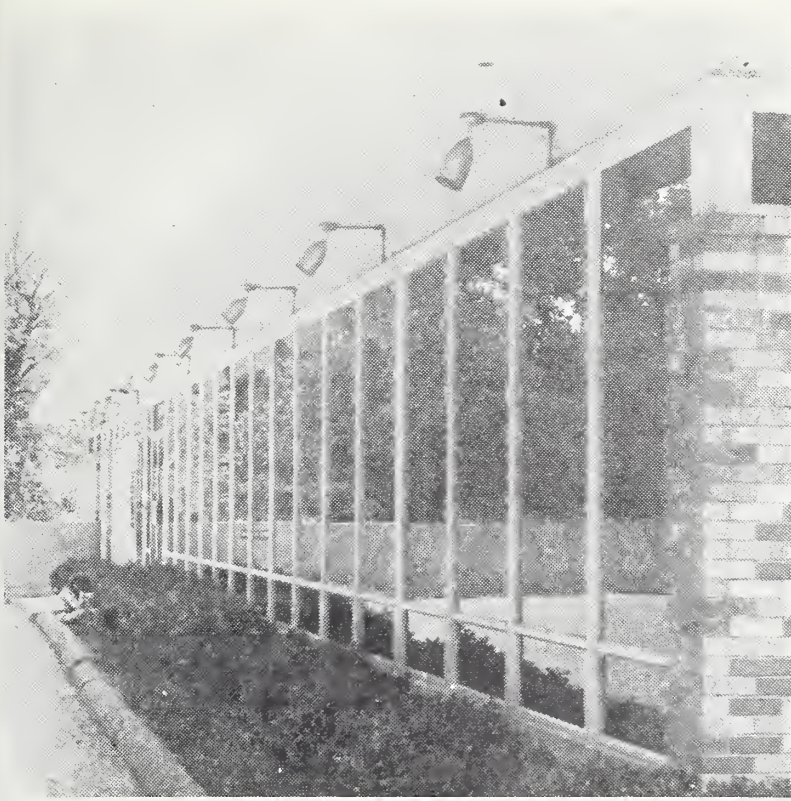
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Peer Review Foundation Publishes Hospital Guidelines

In response to the new hospital Utilization Review Regulations issued by HEW, the Oklahoma Foundation for Peer Review has published a set of Hospital Admission Guidelines for distribution to all Oklahoma hospitals.

The guidelines cover the most common 106 hospital admitting diagnoses. It outlines the criteria for admission under each diagnosis, the usual length of stay in the hospital for the diagnosis by age of patient, complications that would cause extended stays, and a list of the services that are usually rendered and those that might be rendered for the diagnosis.

Publication of the manual became a crash priority project of the foundation when the new Utilization Review Regulations were released by HEW. Published in the November 29th issue of the Federal Register, the regulations required hospitals to have an updated Utilization Review function by February 1st, 1975.

The new regulations require that any elective or emergency admission for Medicare, Medicaid, or Title V patient, must be certified within one working day following the admission. The certification of the necessity for the admission is to be based on written criteria and standards to be selected by the physician members of the hospital's Utilization Review Committee. Such standards are defined as "professionally developed expressions of a range of acceptable variations from a norm or criterion. Norms are defined as numerical or statistical measures of usually observed performance."

Realizing that most small hospitals do not have the staff time or facilities to produce such criteria and norms, the Oklahoma Foundation for Peer Review took it upon itself to assist the hospitals by furnishing criteria and norms that had been researched and developed by the foundation for possible use in a statewide PSRO.

The foundation's guidelines committee, over the past several months, had studied criteria and guidelines from Utah, Texas, Kentucky, Ohio, and Mississippi. The committee recommended that the Mississippi Guidelines be used for the basis of guidelines in Oklahoma. They were to be modified, somewhat, by the inclusion of "indications for discharge" of patients from the Kentucky and Ohio guidelines.

On January 12th the Board of Directors of the Peer Review Foundation accepted the recommendation of the guidelines committee and ordered the OSMA staff to prepare and distribute the Guidelines Manual as soon as possible. Working in conjunction with the printing department of the Oklahoma State Health Department, a limited number of copies of the manual were prepared for distribution.

Each manual contains a cross-index of diagnosis criteria, and explanation of how to use the manual, and an explanation of how to modify the manual for peculiarities of a local situation or to add other diagnosis and criteria to it.

Due to the time limitations, only a limited number of manuals were published. It is anticipated that the manual will be published in handbook form for distribution to all interested persons in the near future. □

Society Named for Former Dean Bird

In recognition of his contributions to medical education, the Robert Montgomery Bird Society has been established to honor the former dean of the Oklahoma College of Medicine.

Created by friends and alumni, the society will sponsor a fund at the University of Oklahoma Foundation, Inc., to be used for lectures, visiting lecturers and support of teaching activities pertinent to the College of Medicine. It is anticipated that part of the funds will be used to sponsor return visits to the school by Doctor Bird.

Contributions may be sent to the Robert Montgomery Bird Society, in care of Mr. Lee O. Teague, Director, Development Office, University of Oklahoma Health Sciences Center, P. O. Box 26901, Oklahoma City, Oklahoma 73190.

All gifts to the society are tax deductible, and contributions are invited and welcome from all physicians and lay persons.

In July, 1974, Doctor Bird resigned as dean of the University of Oklahoma College of Medicine, a post he had held since 1970. He had been a member of the medical college faculty for 22 years.

Doctor Bird left the College of Medicine to become the director of the Lister Hill Institute for Biomedical Communications in Bethesda, Maryland. □

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Legislative Reports Available to Members

OSMA members may now receive the *OSMA Legislative Reporter*. The *Reporter* is published periodically throughout the Oklahoma Legislative Session to keep physicians informed on medical legislation.

David Bickham, Associate Executive Director of the OSMA, edits the *Reporter*. It is automatically sent to all members of the medical association's Legislative Committee and to selected physicians throughout the state. Any physician wishing to receive the *Reporter* should contact the association at 601 Northwest Expressway, Oklahoma City, Oklahoma 73118.

The first issue of the *Reporter* for 1975 was published in mid-January.

It is anticipated that the 35th Legislature of the State of Oklahoma will consider numerous pieces of proposed legislation that could directly effect the practice of medicine. Each of these proposed bills will be discussed in the *OSMA Legislative Reporter*.

The association's Legislative Committee has already taken a position on several bills. They voted to support bills that would waive the physician-patient privilege under certain circumstances, and one that would prohibit the practice of acupuncture by other than licensed physicians. They also went on record as supporting bills that would require insurance coverage for newborn infants, permit the treatment of minors without parental consent, and provide additional laboratory facilities for the State Medical Examiner.

Other proposals discussed by the committee included a state regulation on emergency medical services, state subsidy of internship and residency programs, and a medical review of driver license applicants who have major physical impairments.

When the Legislature convened on Tuesday, January 7th, there were 39 Democrats and nine Republicans in the Senate and 76 Democrats and 25 Republicans in the House of Representatives. Interestingly enough, there will be a majority of first- and second-term members in the House of Representatives. Fifty-seven members could be classified as freshmen. □



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**“Disabled Physician” To Be
Subject of Conference**

Alcoholism, drug dependence and mental disorders existing in the physician population will be the major theme of a national conference on the “Disabled Physician,” April 11th-12th, sponsored by the American Medical Association.

A special invitation to attend the meeting has been sent to all physicians by Malcolm C. Todd, MD, AMA President. Meeting in the St. Francis Hotel in San Francisco, the conference will attract some 300 medical authorities representing various specialties. Participants will examine the motivational aspects, as well as appropriate mechanisms, for encouraging doctors with disabilities, to seek advice and treatment.

Accented during this two-day meeting will be accountability to the public through the assurance of competent patient care. Conference speakers and attendees will focus on exploring alternative formal and informal procedures for the effective treatment, rehabilitation and disciplinary action, when necessary, of the disabled physician.

The role of the medical society, relationships with state licensing bodies and legislative support mechanisms will be other areas of discussion.

Featured on the program are workshops on treatment modalities, treatment facilities and physician re-entry into professional life. The AMA is sponsoring the conference through its Department of Mental Health. The meeting itself is being hailed as a “milestone.”

In his letter of invitation, Doctor Todd said, “alcoholism and drug addiction in physicians, for example, often emerge as problems of significant human tragedy in professional devastation. Now is a critical point in medical history for us to assume and exercise our full responsibility in providing competent care to patients. Accountability within the profession’s ranks and, more importantly, for the public welfare has long been organized medicine’s professional commitment as the healers in society.”

The president also said, “organized medicine, by virtue of its professional commitment to the public welfare, must now work toward developing a more viable strategy of identifying and guiding those physicians who have become disabled because of mental disorders, alcoholism, or drug dependence.” □

**Tutor Funds Needed For
Medical Students**

Tutoring services are being made available to first-year medical students at the University of Oklahoma College of Medicine who might desire, or be in need of them. The tutoring is provided by upper-class students.

In the past, it was up to the individual student to finance his own tutoring. Now, the Office of the Associate Dean for Medical Student Affairs, would like to create a fund that would be available for students who need tutoring. Funds are being sought from physicians, pharmaceutical manufacturers, service organizations, local business people, and interested laymen.

Funds for the tutoring service have already been received from the Insurance Agency of Cravens, Barnhill, Gilbert and Pellow; The Jewish Woman’s Fund; Geigy Laboratories; McNeill Laboratories; and the Searle Company.

Persons wishing to contribute funds should direct them to the Office of the Associate Dean for Medical Student Affairs, University of Oklahoma Health Sciences Center, P. O. Box 26901, Oklahoma City, Oklahoma 73190. □

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DEATH

CHARLES J. ROBERTS, MD
1909—1974

Enid physician, Charles J. Roberts, MD, 65, died on December 7th, 1974. Born in Maywood, Illinois, Doctor Roberts was graduated from Northwestern University Medical School in 1935 and later that year established his practice in Enid. He had long been active in medical affairs, having served as President of the Oklahoma State Board of Medical Examiners and President of the Kingfisher County Medical Society. He was a member of the American College of Physicians. □

OSMA To Sponsor Hawaii Tour in Fall

In conjunction with the American Medical Association's Clinical Session in Honolulu, Hawaii, November 30th-December 5th, the OSMA is sponsoring a ten-day trip for its members.

The trip offers physicians the possibility of combining swaying palms, grass skirts, sandy beaches and continued medical education.

The first seven nights will be spent at the beautiful Hawaiian Regent Hotel on Waikiki. This will give physicians an opportunity to attend either the scientific or business meetings of the AMA's Clinical Convention.

After the AMA Convention is over, two additional nights have been arranged at the magnificent Maui Surf Hotel on the valley island of Maui.

The per person price for the ten days is \$595 in a deluxe room, or \$575 in a superior room. (For some reason, the "deluxe" is better than the "superior" in Hawaii.)

A \$75 per person deposit must accompany reservation forms.

Over the next several months other tours through the American Medical Association's Clinical Meeting will be announced. This one, however, is the only one to be sponsored by the OSMA. Additional information will be made available in the near future.

The association has reserved the entire seating capacity of a Braniff Airline's 747 aircraft.

While the trip is primarily arranged for physicians, the arrangements that have been made by the OSMA will also accommodate any non-physicians who may wish to accompany the tour.

Reservations may be made by contacting the OSMA at 601 Northwest Expressway, Oklahoma City, Oklahoma 73118. □

Book List Available

In the December, 1974, issue of *Postgraduate Medicine, The Journal of Applied Medicine*, is a list of Books in Clinical Practice 1971-1975. A selected and annotated list for medical practitioners, indexed by subject and author, the compilation has been prepared by Kelly M. West, MD, Professor of Medicine and of Continuing Education, University of Oklahoma Health Sciences Center; Ruth W. Wender, MLS, Coordinator of Regional Library Services, University of Oklahoma Health Sciences Center; and, Ruth S. May, MALS, Librarian for the University of Oklahoma College of Medicine Preceptorship Program.

Single free copies of the list are available from the Office of Publications Management, National Library of Medicine, 8600 Rockville Pike, Bethesda, Maryland 20014, which supported, in part, the development of the tabulation. □

CHANGE OF LECTURE DATE

Sixth Annual
**MYRTLE LAUGHLIN
MEMORIAL LECTURE**
in
HEMATOLOGY
NEW DATE:

Tuesday, February 25th, 1975, 4 p.m.

East Lecture Hall University of Oklahoma
Basic Sciences Building Health Sciences Center

Guest speaker, Aaron J. Marcus, MD,
Chief of the Hematology Section, New York
Veterans Administration Hospital, will speak on
"Current Concepts of Platelet Physiology."

Book Review

Essentials of Clinical Endocrinology. By Norman G. Schneeberg, MD, Clinical Professor of Medicine (Endocrinology and Metabolism). Hahnemann Medical College and Hospital; Head, Section of Endocrinology (Hahnemann), Philadelphia General Hospital, Philadelphia, Pa. Clothbound, 449 pp. 210 illustrations and 2 color plates, St. Louis: The C. V. Mosby Company, 1970. \$22.50.

This book came out of publication in August, 1970, and is being offered for review four years later. Obviously it cannot possibly reflect the tremendous strides in endocrinology and related disciplines that have occurred in the past few years. Hence certain sections in the book while reading correct in 1970 may appear "off-beat" when viewed in terms of vintage 1974. For example, a brief statement on "plasma sulfation factor" cannot justify the resurgent interests that have been generated and exciting new data that have accumulated in recent years on the somatomedins; and, the now widely accepted Noonan's syndrome is still discussed under male Turner's syndrome.

In fairness, the author has really succeeded in putting together the vast store of knowledge in endocrinology into a concise and very readable whole. This summation is especially appreciated when one first reads the Preface. "No

attempt is made to compete with the several available comprehensive endocrine text." The book succeeds in distilling endocrine knowledge into a "presentable and digestible essence" thereby easily reaching its intended readers: students, residents and practicing physicians. Even endocrinologists may have occasion to use it to advantage such as in the preparation of teaching slides.

Actually the book offers more. In addition to strictly "clinical" endocrinology, basic understanding of endocrine physiology and biochemistry is assured. The bibliography although somewhat inconsistent in format (some references contain titles, others do not), is well selected and identifies significant reviews. The tables and illustrations including photographs and photomicrographs are well prepared or selected and appropriately captioned. An appendix of common abbreviations at the end of the book helps the uninitiated easily understand their meaning. The division of the book into chapters, sections and subsections bolsters the author's simple style of writing making it readable despite the limitations of scientific discipline.

Again with the qualification that it is four years old, the book could easily be recommended for general medical reading but primarily for the non-endocrinologist interested in endocrinology. *Cosme R. Cagas, MD* □

INTERNAL MEDICINE REVIEW COURSE

East Lecture Hall, Basic Science Education Building
University of Oklahoma College of Medicine, Oklahoma City, Oklahoma

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and
Office of Continuing Medical Education for Physicians
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Send Advance Registration to: Office of Continuing Medical Education for Physicians, University of Oklahoma Health Sciences Center, P. O. Box 26901, Oklahoma City, Oklahoma 73190

DATE TITLE — SPEAKER

February 26, Infectious Disease I—Infectious Disease Section.

March 5, Infectious Disease II—Infectious Disease Section

March 12, Valvular Heart Disease—Eliot Schechter, MD

March 19, Gastroenterology I—Gastroenterology Section

March 26, Congenital Heart Disease In The Adult—Lofty L. Basta, MD

April 2, ASCVD and Cardiomyopathies—Stephen D. Shappell, MD

April 9, Gastroenterology II—Gastroenterology Section

April 16, Metabolic Disorders Presenting In The Adult—Sylvia Bottomley, MD

April 23, Pituitary Adrenalin and Endocrine Hypertension—David C. Kem, MD

April 30, Thyroids and Gonads—E. William Allen, MD

Miscellaneous Advertisements

EXCELLENT OPPORTUNITY for general practice in nice community near Lake Eufaula. Privileges in modern 44-bed hospital. Space available for three GP's in clinic adjoining hospital that already has an abundant patient load. Can expect full-time practice in a short time, along with time off coverage. Guaranteed starting salary — very rapid chance of advancement — with capabilities of earning up to \$50,000.00 yearly. Located in an ideal community from which the patients are drawn from an area of approximately 20,000 population. Ideally located on Highway I-40 and IS-75 — an hour's drive to Tulsa theaters and restaurants and only an hour and a half from downtown Oklahoma City. Only a few minutes drive to Lake Eufaula, Fountainhead Lodge being only 25 miles away. There is a new high school and a new grade school. A small town having all the advantages of a city. A wonderful place for raising children. This is a marvelous opportunity for a family type practice with time off. Call Carlton E. Smith, MD, 918 652-3337, Henryetta, Oklahoma, collect.

NEWLY CONSTRUCTED, multi-specialty clinic in Lubbock, Texas has openings in areas of OB-GYN, Internal Medicine and Family Practice. New 120-bed hospital adjacent to clinic. Top salary leading to partnership. Interested applicants send curriculum vitae to University Medical-Surgical Clinic, 6602 Quaker Avenue, Lubbock, Texas 79414.

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OFFICE EQUIPMENT FOR SALE — 4200 National cash register posting machine appropriately coded for medical practice, used in multispecialty group practice. Would be suitable for backup unit or spare parts. Also available, Edison central dictating unit, consisting of 13 separate phone units, two central receivers, 1 LP TV tape unit and two unit dictators. Will sacrifice. Contact Jim Loy, Chickasha Clinic, 224-4853. □

MAKE YOUR PLANS NOW TO ATTEND

OKLAHOMA MEDICAL SUMMIT '75

This combined meeting of the Oklahoma State Medical Association, the Oklahoma City Clinical Society and the Oklahoma Academy of Family Physicians will feature: Many scientific sessions; a Keg and Oyster Party; a Wine and Cheese Tasting Party; Outstanding guest speakers; a Speaker's Training Program; Inaugural Dinner-Dance featuring the Forrest Wasson Orchestra and many other educational and entertaining events.

April 24 - 26th, 1975

Lincoln Plaza Forum

Oklahoma City, Oklahoma

Health Education—This new designation for the former health careers chairman in medical auxiliary better reflects the emphasis being placed by the AMA, as well as the national auxiliary. "It is a growing belief that any future advances made in improving the nation's health will not result from spectacular biomedical breakthroughs. Rather, advances will result from personally initiated actions that are directly influenced by an individual's health related attitudes, values, beliefs and knowledge. . . . Too few people understand the close relationship between one's health status and one's health behavior. By addressing health problems at each grade level throughout the school years, students are continuously encouraged to develop a life style that fosters good health." This statement from the AMA pamphlet *Why Health Education In Your School?* concisely states the reasoning behind the auxiliary emphasis on Health Education. According to the President's Committee on Health Education, most major causes of death in this country could be prevented if the American public would change its smoking, drinking, eating and exercising habits. But, says the committee, little is being done in the schools toward teaching children how to care for their bodies in order to prevent disease. Because people have a right to make choices about their health, health education is of extreme importance. If they make bad choices, then society pays the bill for health care. Health Education is the only logical answer—teach people to be responsible for personal health care.

On a national level, legislation is pending in H.R. 13084, the "Comprehensive School Health Education Act," with the endorsement of the AMA. On the state level, in January, 1974, the Oklahoma Legislature adopted a resolution "to

upgrade and improve the Health Education Programs" recognizing "health education is the basis upon which individuals make accurate decisions concerning the availability of health facilities and necessary health services and in this way is the key to reducing the costs of health care and improving the total health of the people of the State of Oklahoma." Is it not a more desirable choice that tax monies be spent on a positive approach aimed at changing inadequate health habits rather than on a government funded health care program?

Mrs. Howard Liljestrand, national auxiliary president, set our goals high when she said, "To be champions of school curricula on effective healthful living is certainly a project of great magnitude, continuing need, and one that is appropriate for us to adopt and shepherd. We would make an immeasurable contribution to America if we could stimulate full implementation of health education at the level of comprehension in each grade beginning with kindergarten." The educators in the local school situations are in a dilemma as to how to meet curriculum requirements with an ever-growing list of subjects to be covered within the time limit of school hours that we are accustomed to. They are eager for help! Hopefully, auxiliary members can provide some of that help, while recognizing that schools have the responsibility for health education. Of course, the opportunity to serve on an advisory board with the department of education at local, county or state level is a most gratifying privilege. As resource people who would be available even on a one-time basis, auxiliary members would not only enrich the curriculum studies, but enhance the image of the physician's wife in the local community.—*Sue Medcalf, Health Education Chairman, Auxiliary to the OSMA* □

Guidelines for Hospital Care, a manual published by the Oklahoma Foundation for Peer Review, Inc., has now been sent to every Medicare certified hospital in the state. The manual will assist smaller hospitals in complying with the new Utilization Review Regulations that went into effect February 1st. The manual was published on a crash priority basis in a very limited number. It is anticipated that after each hospital has had an opportunity to review the guidelines and use them for a period of time, the guidelines will then be revised and published in a more compact form for distribution to all Oklahoma medical and osteopathic physicians.

OSMA's Hawaii tour is filling rapidly. The association is sponsoring a tour to Hawaii November 30th-December 5th, during the AMA's Clinical Session in Honolulu. Information was sent out in early January and over 50 reservations have already been received. The tour features ten days and nine nights and includes round-trip jet economy fare from Oklahoma City to Honolulu and a seven-night stay in the Hawaii Regent Hotel in Waikiki. There will then be an inter-island flight to Maui after the AMA meeting with a two-night stay in the magnificent Maui Surf Hotel. Price per person (double occupancy of room) is \$575 for a superior room or \$595 for a deluxe room in the Hawaii Regent. This includes the air fare, bus transfers, baggage handling tips, and the assistance of an experienced tour director throughout the tour. A \$75 per person deposit must accompany any reservation. Persons interested should contact the Oklahoma State Medical Association, 601 Northwest Expressway, Oklahoma City, Oklahoma 73118.

Although new National Health Insurance proposals are being filed each week with Congress, at least four congressmen feel that NHI will not pass this year. Al Ullman, (D-Oregon), Chairman of the House Ways and Means Committee, told a recent meeting in Chicago that he hoped that any NHI plan would build on the present system. Paul G. Rogers (D-Florida), Chairman of the House Sub-committee on Health, predicted passage of an NHI bill by the end of 1976 and said he was optimistic that free enterprise would be retained. Two other members of the House Ways and Means Committee,

Omar Burleson (D-Texas) and John J. Duncan (R-Tennessee) expressed similar views. The Chicago meeting was the AMA's Annual Leadership Conference for Medical Society Officers and Executives.

Physician volunteers are being sought to staff the OSMA's First Aid Station in the Capitol building during the months of April and May. The station is open during the Legislative Session, Monday through Thursday, and is staffed by voluntary physician and registered nurse. The station itself is well-equipped and has an excellent stock of pharmaceutical products. Any physician wishing to volunteer should send his name and preferred dates to the OSMA in Oklahoma City.

Doctors' Wives Day at the Legislature, a program sponsored each year by the OSMA Woman's Auxiliary, will be held March 5th. The all-day meeting will start at 9:00 a.m. in the Supreme Court Chambers on the 2nd Floor of the State capitol building. The tentative program calls for a welcome by Governor David Boren, an explanation of the legislative process, and then a panel discussion with four members of the Oklahoma Legislature. Lunch will be served at 12:00 p.m. in the OU Health Sciences Center's Faculty House. Guest luncheon speaker will be Thomas Lynn, MD, acting Dean of the OU Medical School. The afternoon will be taken up with scheduled tours of the Health Sciences Center. Ladies interested in attending the meeting should contact the OSMA.

A revised health insurance claim form has been published by the American Medical Association. It was designed as a single form that would be acceptable to physicians and third party payers for claiming and processing Medicare claims. The Bureau of Health Insurance has stated that it will approve the use of the new form in lieu of the existing SSA-1490 when other major third party insurers in an area also are willing to use it as their claims form. Stumbling block to use of the form in Oklahoma is the state law requirements for certain disclaimers to be included in all contracts on its form in order to be in compliance with the law. Until such time as the law can be changed, or some alternative method worked out, it would appear that the AMA's form will not be acceptable to Medicaid, and therefore not to Medicare. In the meantime, the new form can be used for health insurance companies. Copies of the form may be obtained by writing the AMA, 535 North Dearborn Street, Chicago, Illinois 60610. □

The

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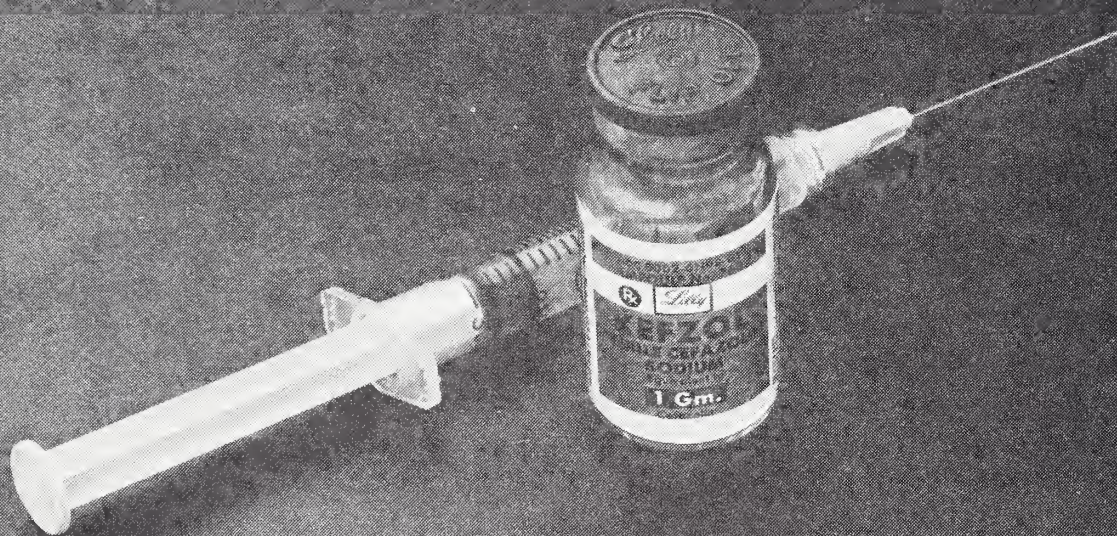
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The Malpractice Malady

The frequency and the size of malpractice awards have in recent years reached almost crisis proportions. The time is long past due for the recognition of this fact and there is serious need for corrective action. Malpractice insurance has become a nightmare to the insurance carriers, an overwhelming burden to the practitioners and a lottery prize to the willing patient and calculating attorney. Insurance companies and doctors are both victims of the same situation.

Physicians never have expected amnesty from, absolution for, or minimization of actual negligence or error. So long as medicine and surgery are practiced by human beings there will always be the possibility of error. As a matter of fact, judging from experience now had with computers, it is quite apparent that there will be less error by the human than by the machine. Yet no profession or group of individuals has been so severely attacked and penalized as have the doctors. This has led to a very careful appraisal of how doctors should attempt to avoid the problem, but far too few are doing far too little about correcting unfair legal aspects. Many have asked the medical profession to police itself to minimize unfortunate results but no one has ever proposed sufficient regulations regarding lawyers' activities in pressing unfair claims.

The legal profession, just as the medical profession, consists for the most part of respected and honorable constituents; however, both professions have some venal, unscrupulous members.

In our neighboring nation of Canada, the medical and legal professions are not faced with the morass of constricting laws and their interpretations that we contend with in the US. Legal work on a contingency basis is illegal and unethical. The Doctrine of *Res ipsa loquitur* is not applicable. Malpractice cases are tried by judges and not juries and damages for pain and

suffering are not allowed. Compassion is not so likely to replace logic and fairness.

The finest possible ongoing education will not eliminate all mistakes, because no physician is perfect. When such an imperfection becomes manifest in the care of a patient, is it right that a patient's situation be compensated only by a malpractice suit against the physician? Instead of such a rationale a more equitable solution would be provided by participation of the patient in an insurance plan that would protect both patient and physician.

It is a foregone conclusion that constant vigilance by the medical profession must be had for the prevention of repetition of mistakes and dangerous practices and to avoid educational obsolescence. Peer Review is a must to provide high quality care. On the other hand, professional and economic assassination are rarely justified.

CAUSES

One of the greatest causes of the problem is the contingency fee of large size that has been permitted the claimant's attorney. This has in many areas amounted to 50% of the award and in hardly any instance has it been less than 33% of the award. The attorney then is no longer a counselor or representative of the claimant, nor is he even just an advocate, but becomes a partner of the claimant and even a proprietor of the lawsuit. This results in an incentive from the monetary standpoint that is too great for the mortal barrister to resist and the attack becomes something more than vigorous. The lawsuit becomes not only an attack, but soon an harassment and, finally, a vendetta. As a result of the implications, innuendoes and actual accusations, the result is often a punitive verdict of exorbitant size far out of proportion to the merits of the case. This triggers off other cases for financial gain.

It is easy to see that this results in a discrimination against doctors and their in-

surors, because the awards for the same disabilities when sustained under medical circumstances are much greater than awards for the same disabilities sustained from other causes. For instance, the family of a pedestrian who is killed by a dumptruck seldom receives as large an award as does the patient who dies on the operating table. The commercial driver, in charge of brakes, speed, gear and overload — as much the legal "captain of his ship" as any operating surgeon — may very well have come barreling down a hill. The complexion of unavoidable "accident" is put on the event and, unless the driver is under some undue influence such as drugs, he is rewarded with a trivial citation for "improper maintenance," "speeding," or "following too closely." The civil liabilities, however, are isolated for convenient assault in a second person, some distance away, the owner of the vehicle, and the recoverable damages are limited to the size of his insurance, if any.

In the case of the physician the tort and the civil liability exist in the same person covered necessarily by enormous insurance.

The commercial driver is up to his neck in immunity, protected by the political power of the trucking industry, the insurance industry and the mythical nature of highway "safety" or "mechanical failure." The physician, contrariwise, is up to his neck in liability, surrounded by *Res ipsa loquitur*, the flexible doctrines of diligence and reliance, the imminent doctrine of infallibility and a ready accessibility of the assets. The case is readily documented. It is more profitable to leave negligence law in the dark ages and to see that nothing effective is done to reduce slaughter on the highway.

It is obvious that part of the problem is due to case-building and witnesses can always be obtained for a proper price, much of the testimony being a gross mishandling of the truth.

Another problem is the assumption that a bad result is prima facie evidence of malpractice unless a doctor can prove himself innocent, this being the exact opposite of the assumption held in all other legal matters. One California judge, surprisingly enough, has gone so far as to state that, regardless of the facts in the case, the doctor and his insurance company are the only ones capable of meeting the financial requirements of the claimant and therefore the award should be made for the claimant and against the

doctor! This ridiculous twist of logic and jurisprudence should have no place in our American society, let alone exist in our courts of law.

Much has been said and written to the effect that a major cause of legal action against the doctors is due to a decrease in the consideration of the doctor for the patient. This simply is not so. Most assuredly the horse and buggy doctor no longer exists, but today the patient would not want such a physician. In past years the doctor could offer little more than his mere presence and personal attention. The modern doctor, though much busier, has no less a consideration for, and sense of obligation to, those in his care. The pressure of his work is reflected in the high incidence of mortality from heart disease in members of the medical profession. The modern doctor is very well aware of his duty. His practice and the success of it are dependent upon the satisfaction of his patients and he deeply resents anything that interferes with the mutual trust that should exist between them.

EFFECTS

1. Some doctors are avoiding high risk cases.
2. Some doctors are accepting early retirement to avoid high insurance premiums and malpractice action.
3. Ultimate reduction in doctor availability to the public will occur.
4. Lessening of confidence of the patient in the doctor, or conversely of the doctor's faith in the patient, thus creating a mutual breach unnecessarily. Harmonious interpersonal relationships and trust are necessary for the most effective health care.
5. Decrease in medical progress and development of new techniques and methods by stifling the use of certain heroic and original measures that might very well be more effective.
6. Decrease of interest by prospective medical students in the practice of medicine and surgery.
7. Increased cost of medical care to all by the necessity of practicing "defensive medicine," with a super-abundance of tests, x-rays, reports and legal advice.
8. Interference with sound surgical judgment occurs. Doctors have lost legal cases when surgery was withheld as well as when they have operated and a bad result ensued.
9. Malpractice insurance rates are becoming prohibitive and in some cases insurance not available at all. Between 1960 and 1970 liability insurance premiums for all physicians in-

creased 539% and for surgeons skyrocketed 951%.

REMEDIES

1. Eliminate the contingency fee. Both claimants attorneys and defense attorneys not only evince little interest in this recommendation, but also seem to become a little frantic when it is mentioned. Perhaps they like the adversary system to remain status quo. They should be reminded, however, that a contingency fee has been outlawed in every other English-speaking country in the world and in all European countries on the continent with the exception of Spain. It produces excessive incentive to file a lawsuit. Under the present system it costs the unhappy patient nothing to sue; human frailty cannot resist such a temptation. Some have said this amounts to a "free roll of the dice."

The time-worn contention that the contingency fee allows the poor man to be represented is shallow indeed. If the compassion of our legal friends is actually that great, why do they walk away with such a large part of the award — 33% to 50%?

There is a better method in which the attorneys can represent their clients and still be remunerated. It will be a simple matter to establish rotating panels of attorneys willing to handle such cases for proper fees and these panels could be established by the courts. It is interesting to note that the attorneys have such panels acting as Legal Aid Societies wherein such cases as divorces and small claims can be handled. Public defenders are even available to murderers. On the other hand, it is obvious that a client never seems to have any difficulty in finding representation when a malpractice case is in the offing, since the reward may be much greater. A government legal program for the poor could be established; this would be no less logical than a government medical program.

To correct the contingency fee problem will obviously be quite difficult, due to formidable political and constitutional barriers set up by plaintiffs lawyers, many of whom are in state legislatures. Nevertheless the fact that this situation exists only in the United States should tell them that it is long past due that this matter be corrected.

2. Establish through courts the maximum attorney's fee that is practical and judicious in each case and allow this knowledge to be known to a jury before its deliberation, just as

medical fees are revealed. Doctors are often asked on the witness stand to disclose their charges both for treatment and for testimony and it would seem only logical that the attorney should declare his possible financial gain from representing his client.

3. Remove discriminatory and punitive awards against physicians. Awards have now exceeded \$4 million. This obviously is partly due to an attempt to be punitive in rendering such a verdict and yet it should be apparent that no physician would desire the occurrence of a bad result. Not only does it harm his practice and assault his pride, but it may very well render his family and himself bankrupt. The entire malpractice litigation experience is traumatic, expensive and time-consuming to any doctor.

4. Eliminate abusive treatment of the doctor witness or defendant as well as all others giving testimony. This has been effected in most other countries.

5. Eliminate inflammatory evidence such as bringing into the courtroom the amputated extremity in a brown butchers paper and proceed to draw an analogy. This has also been eliminated in other civilized countries.

6. Insist that the plaintiff, in event that the case has no merit and the court rules against him, be made to pay the court costs and fees of the defense attorney. This is done in Great Britain, Canada, Australia, New Zealand and elsewhere. It will help to diminish nuisance suits filed simply to extort a settlement.

7. Eliminate the splitting of fees among attorneys. This practice has been outlawed in the medical profession long ago. Actually, though apparently unknown and unobserved by many attorneys, it is also forbidden by Canon 34 of the American Bar Association when the referring attorney has no active participation with the case or responsibility for it. Some attorneys who do not care to soil their hands by an unjust malpractice case are not above referring it to someone who will and then, though remaining in the background, share in the profits. This increases the frequency of malpractice suits and many are filed that have no merit. Up to now the plaintiff's attorney has never been seen to list his fee on the well known courtroom blackboard.

8. Reduce the application of *Res ipsa loquitur* to the obvious, as it once was. Many complications are simply not explainable. The burden of proof should be on the plaintiff, as in other

legal matters. To infer negligence is frequently unjust.

9. Return to the acknowledgement that the doctor should be considered innocent until proven guilty.

10. Emphasize that a bad result does not in itself indicate malpractice and that certain occurrences or accidents are unavoidable. Perfect results are not the rule.

11. Consider the development of "medical accident insurance," "professional casualty insurance," or "maloccurrence insurance" whereby the victim may be compensated a reasonable amount without wrongdoing being proved and without indictment of the doctor, as in auto accidents and other types of casualties and catastrophies.

It should perhaps be pointed out that "no fault" insurance would not be a practical solution. This would simply result in a large volume of small claims and great expense without eliminating the large claims already occurring.

12. Utilize a panel of impartial experts to determine the degree of disability, thus allowing the monetary amount to be determined by an informed court. In a somewhat similar fashion, utilization of arbitration committees of informed individuals could be established along the lines of industrial courts. Compensation there is provided regardless of fault.

13. Establish a limit of recovery, perhaps some such figure as \$50,000, with legal fees based on time and effort expended and not to exceed fees for other civil action; or, at least, do as New Jersey has done and by law effect a decreasing scale of legal fees as the size of the awards increase, this referring to the percentage of the award.

14. Allow insurers to make advance payments to plaintiffs for medical care and other expenses before the issue of liability is resolved. This could improve the emotional climate in serious injury cases.

15. Permit either side to request a preliminary trial on whether the statute of limitations has expired before the substance of the suit is tried.

16. Possibly consider that all individuals carry insurance of their own for unfortunate results. If each individual in the United States paid one dollar a year, this would result in a fund of over \$200 million, much more than

has been spent in recent years in malpractice action. As the matter now stands, 200,000 doctors, 0.1% of the population, are carrying insurance for a population of 200 million. Very possibly the federal government will someday step in. Senator Ribicoff and his committee have recognized the seriousness of the situation. Most assuredly legal fees would then be controlled.

17. Develop an assigned risk pool for doctors in vulnerable practices.

18. Lastly consider becoming "suit-proof" by transferring all funds to wife or by other legal procedure.

The time is long past due for a complete review of this serious problem and for logical corrections to be effected. Progress will require the cooperation of the more high-minded of the legal profession.

During the past few years an award was made in the Florida court to a patient for \$1,800,000 and the attorney had a 40% (contingency fee) contract. This amounts to \$720,000. There is no way to justify such a fee. Obviously the case was presented to the jury with figures designed to prove the \$1,800,000 was due the patient for pain, suffering and medical expenses. Yet the attorney walked away with 40% of it! So who was lacking in compassion?

A very interesting thing happened when the award was declared — the claimant's attorney fainted. Now it is a well known fact that a healthy individual usually faints because of fear, surprise or pain. It is pretty apparent the lawyer was surprised; surely it was not from fear or pain.

In past years our various medical organizations have demonstrated very little effect in correcting the very unfair results of malpractice actions. All too much timidity is shown in facing up to the legal profession and legislators, the unfair jeopardy resulting from the contingency fee and the astronomical awards. True enough, it will not be easy to get through state legislatures corrective legislation. A national program of public information must be mounted. Certainly something must be wrong in the present laws allowing contingency fees when we are the only advanced country in the world that permits it. When doctors find themselves without insurance coverage, the practice of their profession will no longer be possible and the public cannot be served. *Jack L. Richardson, MD* □

Medical Malpractice

Recent Developments in Oklahoma

JOSEPH A. SHARP
JOSEPH F. GLASS

The malpractice climate in any state is established by the trends in its court system. Recent decisions in Oklahoma courts indicate that Oklahoma has a health professional liability situation. This article is a review of those recent decisions and their impact.

Since 1972, the Supreme Court of the State of Oklahoma has rendered several interesting legal opinions concerning the area of medical malpractice. The opinions concern themselves primarily with the Doctrines of *Res ipsa loquitur*, Informed Consent. It is the purpose of this article to inform the medical profession of the standards and attitude of the Supreme Court of the State of Oklahoma, with respect to the above doctrines in the area of medical malpractice.

In the case of *Holland v. Stacy*,¹ the evidence established that the plaintiff was hospitalized for treatment of gangrenous toes. For five days he was given substantial doses of an alcoholic

stimulant and another drug called "elixir of Roniacol." After several days, the plaintiff complained that the medications were making him nauseous. Near the end of the fifth day, the patient became blind. His condition was diagnosed as "retinal central arterial thrombosis." An AMA publication on drugs stated that the drugs administered to the plaintiff could be harmful to patients with cerebral vascular diseases. The defendant-physician admitted that he was aware that the plaintiff had previously been hospitalized with a condition diagnosed as "cerebral vascular lesion, type unknown, but probably thrombosis."

The trial court found that the Doctrine of *Res ipsa loquitur* or presumed negligence did not arise under these facts. To be hospitalized for gangrenous toes and after five days of internal medication to awaken blind is not such an extraordinary event as to raise an inference of negligence. For a plaintiff to apply the Doctrine of *Res ipsa loquitur*, the evidence must establish "what thing caused the injury." Here, there was no evidence establishing that either the alcoholic stimulant or the elixir of Roniacol or a combination of the two caused the blindness of the plaintiff-patient. Therefore, the court rendered a judgment for the physician-defendant.

In the case of *Martin v. Stratton*,² the evidence established that the plaintiff-patient entered the hospital to have a tumor removed

from his hand. The defendant-physician administered a brachial block anesthetic, by injecting a hypodermic needle into the brachial plexus area of plaintiff's right shoulder. The patient felt two sharp pains in the shoulder area and then lost consciousness. Following the operation and after the numbness had subsided, the plaintiff-patient suffered severe pains in his shoulder for six weeks. Three years later, he had not regained full use of his arm. The evidence further established that the plaintiff-patient suffered a partial loss of the axillary nerve supply to the deltoid muscle. As well as claiming the application of the Doctrine of *Res ipsa loquitur*, the plaintiff also claimed the lack of informed consent.

The defendant-physician's evidence established that there were possible causes of the injury other than the administration of the block. Other possibilities included positioning of the arm during or after surgery or acts occurring in the recovery room. The physician's evidence also showed that the proper administration of the block causes a tingling feeling along the nerve, down the arm, similar to that of a mild electric shock. Therefore, the court held that the Doctrine of *Res ipsa loquitur* was not applicable since it was not established by the evidence "what thing caused the injury." Insofar as the plaintiff-patient's claim of a lack of informed consent, the court indicated that if the theory of informed consent was ever adopted by this state, the plaintiff must show that the defendant-physician failed to disclose what a reasonably prudent physician in the medical community in the exercise of reasonable care would disclose to his patient, or that there existed material risks which were inherent in the proposed medical procedure in the terms of seriousness, probability of occurrence and feasibility of alternatives, and the defendant-physician failed to disclose these risks to the plaintiff.

The court found that there was no evidence from which a jury could have reasonably inferred that material risks, in terms of probability and seriousness of consequence, were inherent in the administration of the anesthetic. Neither was there evidence to establish that the probability of an injury such as the plaintiff's was of such magnitude that a patient deciding whether to submit to the procedure should be warned of the possibility. The evi-

dence indicated that this type of injury resulting from such an injection was extremely rare. Therefore, the Supreme Court affirmed the lower court's decision in holding for the physician.

In *Murray v. Vandevander*,³ the plaintiff sued the defendant-physician for loss of consortium and the right to produce another child. The evidence showed that the defendant-physician performed a hysterectomy upon the plaintiff's wife without the plaintiff's consent. The defendant-physician had obtained the consent to perform the operation from the plaintiff's wife. Before the surgery, the plaintiff warned and specifically notified the defendant-physician that he strenuously objected to the surgery being performed on his wife.

The court held that the choice of whether a woman will or will not bear any more children is strictly her decision, and the consent of the husband is not necessary.

In a 1973 case *Karriman v. Orthopedic Clinic*,⁴ the plaintiff-patient sued the defendant-physician for a breach of warranty and a lack of informed consent. The evidence established that the plaintiff had been having back trouble and other related problems for approximately a year. The defendant initiated conservative treatment which did not improve the patient's condition. Thereafter surgery was recommended and performed. Complications developed and a second surgery was performed. Additional complications developed, including numbness and abnormality in the genital area and "dropped feet." The plaintiff-patient claimed that the defendant warranted a cure through surgery and did not inform him of the possible severe complications that could result from surgery. There was a sharp difference in the testimony of the plaintiff and defendant as to what assurances were made.

The court quoted verbatim the following "Consent to Operation" taken and signed by the plaintiff:

I hereby authorize Dr. (name of doctor or doctors performing the operation) and whomever he may designate as his assistants to perform upon myself (State name of patient or 'myself') (To be filled in by patient) the following operation (*Here the November 13th Consent stated, among other things: 'Laminectomy & disc removal, . . .'; Here the November 16th Consent stated: 'Reexploration of lumbar*

region and possible Laminectomy’;) and if any unforeseen conditions arise in the course of the operation calling in his judgment for procedures in addition to or different from those now contemplated, I further request and authorize him to do whatever he deems advisable.

The nature and purpose of the operation, possible alternative methods of treatment, the risk involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained.

I consent to the disposal of tissues, to photographs of operative parts, and admission of necessary personnel into the operating room, or persons deemed necessary by attending surgeon. I certify that I have read fully and understand above consent to operation; that the explanations therein referred to were made, and that all blanks or statements requiring insertion or completion were filled in and inapplicable paragraphs, if any, were stricken before I signed.

Witness(s): *Amelia Stark* Signed *Joseph Karriman, Jr.*

The plaintiff testified that he did not read the consent form because of what the doctor had told him. The court stated:

While he and his wife testified to statements made by Dr. M to them, that might be interpreted as having painted an optimistic picture of the possibility of

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the disc protrusion’s removal alleviating plaintiff’s problems, or at least not worsening them, and we question the admissibility of such parol evidence to contradict the statements in the above quoted writings . . .

The court further found that it was no excuse that the plaintiff did not read the consent form.

The “Consent to Operation” set forth above is an extremely well drawn instrument and its use is highly recommended to all doctors who perform any surgical procedure since it covers almost every possible eventuality.

As to the breach of warranty claimed by the plaintiff-patient, the court held that the physician is not responsible for damages for want of success, unless it is shown to be a result of a want of ordinary skill and learning, such as ordinarily possessed by others of his profession. Therefore, the Supreme Court affirmed the judgment for the defendants.

In a 1973 case *Runyon v. Reid*,⁵ an action of malpractice was brought by the decedent’s widow against a psychiatrist, a general practitioner, a mental health foundation and a pharmacist as a result of an overdose of sleeping pills. The evidence established that the decedent suffered from a serious emotional disorder, and had been admitted to the hospital for the mentally ill on three occasions in the years of 1945, 1947, and 1956. The second hospitalization occurred after an attempted suicide. A year after his last hospitalization, the decedent became a patient at an outpatient clinic owned by the defendant foundation. In 1963, the decedent’s condition became more severe and he was referred to the defendant-psychiatrist. The psychiatrist continued to treat the decedent and diagnosed the condition as schizophrenia. The psychiatrist did not regard the decedent as suicidal in nature. From 1959 until the patient’s suicide, the general practitioner treated the decedent for various physical ailments. The foundation, psychiatrist and general practitioner all had prescribed drugs for the decedent. The general practitioner had prescribed Carbrital for the decedent on several occasions. The defendant-pharmacist had filled several of the prescriptions for the decedent. However, on the date before the suicide, the decedent refilled the prescription for Carbrital without the approval of the prescribing physician. Thereafter, the decedent committed suicide by an overdose of Carbrital.

The court in holding for the defendants, made several observations which will interest the medical society. First, where neither mental health foundation, psychiatrist nor general practitioners prescribed the particular sleeping pills, which the decedent used to voluntarily commit suicide, and there was no indication that the decedent was suicidal in nature, they were not liable for the decedent's death. Second, with respect to the pharmacist, the court made some interesting observations. The pharmacist who refills non-refillable drug prescriptions without a physician's permission, should not in all circumstances, be liable for the death of the purchaser who uses the drug so obtained to commit suicide. The statute which prohibits the druggist from refilling prescriptions without the physician's permission does not impose an affirmative duty upon the pharmacist to protect his customer from the customer's voluntary act of suicide. Further, the court stated that where the decedent willfully committed suicide by taking an overdose of a prescription drug, knowing the physical

effect of his act, such action constituted an independent, intervening cause and the pharmacist's negligence in refilling the prescription without the physician's permission was not the proximate cause of the decedent's death.

The authors feel that the members of the medical profession should be encouraged by these recent opinions. The trial courts backed by the Oklahoma Supreme Court are requiring strict proof of negligence in most medical malpractice cases. The courts are not allowing a presumption of negligence to arise just because a patient does not get well. We feel that our Supreme Court is taking a fair and moderate approach to the extremely serious problem of medical malpractice litigation and that those reported cases will discourage the filing of such questionable cases in the future. □

References

1. Holland v. Stacy, 496 P. 2d 1180 (May 2, 1972).
2. Martin v. Stratton, 515 P. 2d 1366 (October 23, 1973).
3. Murray v. Vandevander, 522 P. 2d 302 (April 16, 1974).
4. Karriman v. Orthopedic Clinic, 516 P. 2d 534 (Nov. 20, 1973).
5. Runyon v. Reid, 510 P. 2d 943 (March 13, 1973).

200 Franklin Building, Tulsa Oklahoma 74103

CERTIFICATION EXAMINATION

for

AMERICAN BOARD OF FAMILY PRACTICE

The American Board of Family Practice announces that it will give its next two-day written certification examination on November 1st-2nd, 1975. It will be held at five centers geographically distributed throughout the United States. Information regarding the examination may be obtained by writing:

Nicholas J. Pisacano, MD, Secretary
American Board of Family Practice, Inc.
University of Kentucky Medical Center
Annex No. 2, Room 229
Lexington, Kentucky 40506

Please Note: It is necessary for each physician desiring to take the examination to file a completed application with the Board office. Deadline for receipt of applications in this office is June 15th, 1975.

How To Be A Defendant

GEORGE F. SHORT
NANCY C. LAUGHLIN

A malpractice lawsuit can be a traumatic experience to a physician. Current figures indicate that one out of every six physicians in Oklahoma will be sued at some time during his professional career. In this article two knowledgeable attorneys discuss ways a physician can avoid such suits and then what he should expect in the unfortunate event that he becomes embroiled in one.

Not so many years ago, a physician in Oklahoma could expect to practice throughout his professional life without so much as the threat of a malpractice claim, much less the filing of an actual suit. In all probability, this was not particularly the result of the lay person's or the patient's understanding of the problems confronting the physician in his diagnosis and treatment of the patient; it was more the result of a feeling of closeness and respect for the physician on the part of the patient, coupled with the reluctance of lawyers to file such suits.

Formerly, most trial lawyers who customarily represented plaintiffs, or the persons making claims, made their "bread and butter" from the litigation of automobile accidents. In order to increase the amount of their client's damages, it was necessary that they have testimony from physicians to say that the client had indeed suffered substantial injuries resulting from the accident, and therefore they were reluctant to antagonize the medical profession by the filing of malpractice lawsuits. However, it has become evident that some form of no-fault insurance will soon be in effect in all states. The provisions of this type of insurance create a situation in which personal injuries arising out of automobile accidents will not be litigated unless the injuries are both perma-

nent and substantial, so substantial that they will be obvious to a jury without embellishment by a friendly expert witness, a physician.

At the same time, the personal feelings formerly had by the patient for his or her physician have been diminished by two things: First, the increasing importance of the specialist, who often does not see the patient until a crisis has developed, and secondly, the increasing transience of the population, which decreases the patient-physician contact and the development of a patient-physician relationship. Thus, the malpractice claim and the malpractice lawsuit have suddenly proliferated in an almost unbelievable fashion, due to sociological factors which have no bearing whatsoever on the actual quality of care rendered to the patient.

Physicians of national standing and impeccable credentials now find themselves with not one, but two or even several pending malpractice claims or filed lawsuits, and whether the patient's claims are eventually handled through government intervention or any other means, any realistic physician who embarks on the practice of medicine must be prepared for the fact that at some point in his professional life, his professional competence with regard to the handling of a given patient will be questioned, and compensation will be sought by that patient for a less than perfect post-treatment result.

At present, the physician or his insurer is required to compensate the patient for an undesirable result only where legal fault on the part of the physician — a "departure from the standards of medical practice in the community" — can be established in court by expert testimony. It is, therefore, part of every physician's professional education to be cognizant of our present system of deciding such claims, of those practices which should be avoided in order to avert the malpractice claim, and, perhaps more importantly, since a claim may arise even when the physician has rendered the best of treatment to the patient,

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to know how to conduct himself most effectively when a claim arises.

WHAT CAUSES A MALPRACTICE SUIT?

The law gives a physician a rather realistic latitude in defining what constitutes actual negligence. The mere fact that a physician may have made a mistake in diagnosis or in the selection of treatment does *not* mean that the physician was negligent. The law recognizes that, even within the bounds of what is legally termed as "the standard of the community" a physician is not omniscient; for example, a physician is never held to the standard of what would have been the appropriate treatment in light of subsequent developments, unless those subsequent developments should have been foreseeable to the physician at the time he selected the treatment. This does not prevent patients from filing malpractice claims whenever they are confronted with the natural progress of their own disease process, or with any result of treatment which they consider undesirable.

As lawyers defending malpractice claims, we see many motives for the filing of such lawsuits aside from an actual feeling on the part of the patient that the doctor was negligent. Some motives predominate; often, a parent or other family member feels guilt at not seeking medical help soon enough, or for some other personal reason, and this guilt can, for obvious reasons, be alleviated by placing the blame on the physician. The housewife who is getting no attention, or whose husband has lost interest in her, finds a sense of importance in righteously pressing her claim against a physician, and an amazing number of these women claim that sexual relations with their husbands are painful when, in fact, there could be no possible relationship between their illness and complication, and their ability to enjoy a full sexual life. Likewise, we see the male, who, having lost interest sexually in his wife, is eager to characterize himself as having been rendered impotent by the surgeon who performed a transurethral resection, despite the fact that there is no known physical cause for impotence following such procedure. Finally, there is the patient who simply develops a dislike for the physician, often for reasons totally unrelated to the quality of medical care; perhaps the doctor spoke too bluntly to the patient or a member of his family, or perhaps the

physician, albeit unrelated to the necessity of caring for the patient adequately, was not present on some occasion when the patient needed or desired emotional support.

It is important for the physician to keep in mind that, should he be sued, his attorneys are probably aware of these collateral motives, and that he as a physician need not waste time convincing his attorneys that he did in fact render excellent care to the patient. Likewise, the physician who has been sued should not feel that his competence is in question, in light of the many reasons that lawsuits of this type are filed, totally aside from any failure in professional treatment by the physician.

WHEN SUIT IS FILED

Although most insurance policies require you to report potential claims to your insurance company even before a lawsuit is filed, you will probably not come into contact with the defending lawyers until the Petition and Summons are served upon you. Whatever events have preceded the filing of a petition cannot be altered, but the conduct of the physician in relation to his attorneys can be of utmost importance.

More than one lawsuit has been settled where no possible negligence on the part of the physician could be determined by the lawyers, simply because the physician was so difficult to deal with in terms of preparing him to be a witness in his own behalf. Most professional liability policies carry a cooperation clause, which stipulates that liability coverage will be extinguished should the insured fail to cooperate with the insurance company or the lawyers hired to defend the physician. As a practical matter, no matter how difficult to deal with the physician may make himself, coverage is rarely destroyed on this basis, but the physician's attitude toward his insurance company and his lawyers has an untold effect on the amount of settlement which the lawyers are willing to recommend as opposed to the prospect of going to trial.

First of all, it is well to keep in mind that, since your insurance company as a writer of company malpractice coverage, probably has a great number of such policies, the lawyers which they have employed to protect your interests are probably thoroughly familiar with the malpractice claim. In a sense, they are specialists, just as is the physician who has gone through a residency and who restricts his

practice to a particular area of medicine. Not only are these attorneys thoroughly familiar with the problems of malpractice litigation, but they are thoroughly familiar with the problems you face as a physician, and the tremendous value of your time. Nonetheless, it is imperative that they make certain demands upon your time in order to properly defend you and protect your interests. If they are familiar with the problems of a physician, they will try to schedule all time required of you in the manner most convenient to the demands upon your time by your professional practice. However, they may be required by actions on the part of the lawyers on the other side to be present suddenly at the pre-trial testimony, by deposition, of certain witnesses. Before attending the depositions of these witnesses, they might desperately need to confer with you on short notice; it is always in the best interest of the physician to make himself available for such conferences, even though it may be inconvenient, and to realize that this is not a whim of your own attorney, but rather a matter of circumstantial pressure exerted by the other side.

One of the most frequent tasks which the defendant physician is first required to perform is the answering of *interrogatories*. These are questions which are made up by the plaintiff's attorney and served upon the defendant physician. They are not the creation of the physician's attorney, nor is there anything which your attorney can do to avoid the answering of such questions. The answers must be returned to the plaintiff in writing within a

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limited time period, and the answers are under oath. They may be used in trial of the lawsuit to cross-examine you as the defendant, and are therefore of great importance. It is therefore necessary that they be answered accurately and completely, and this is often a burdensome task. This is the physician's first opportunity to cooperate fully with his attorney, and just as much attention should be devoted in the preparation of answers to interrogatories as would be devoted to answering correctly the questions of the plaintiff's lawyers at trial.

Physicians as defendants are an unusually intelligent and cognizant group of clients for the attorney; in many respects they can be a pleasure to work with. However, a physician can make himself, to the attorney, what an hysterical and distrustful patient is to the physician. The attorney is definitely interested in knowing whether or not you consider yourself to have made an inexcusable error, a medically acceptable error, or no error at all. However, the attorney is totally willing to accept your viewpoint, and no time need be devoted to convincing your attorney that the patient is crazy for bringing the lawsuit, or that the patient's lawyer is unscrupulous and worthy of disbarment for filing the lawsuit. It is more important to devote your attention to educating your attorney to the medical reasons why you acted as you did.

Many physicians who are sued are so concerned with the injustice of the claim that it is difficult to communicate with them as to the factual aspects of the case. We actually encountered recently a major case in which a postoperative complication was reported by a second physician. The defendant, our client, did not believe the complication occurred. As a practical matter, we could not call the second doctor a liar, (the jury would have been offended) so, it was necessary to answer the question: "Assuming this complication did occur, how can we explain it? How did it happen without negligence?" Our defendant doctor, highly qualified in his field, never got past the point of "assuming," which he adamantly refused to do. The answer was supplied by another person in the field, with whom we consulted, and the case was successfully defended. However, its defense was truly jeopardized by the defendant's over-concern about the observations of his colleague, and the defendant's unwillingness to turn his attention from that focal point to the real problems we outlined to him.

A Defendant / SHORT, LAUGHLIN

A common question asked by the physician who knows that he has been unjustly sued is, "Can I bring countersuit for (slander) (malicious prosecution)?" Such a countersuit is rarely a feasible alternative, for the law will not penalize the patient or his attorney for their ignorance of the propriety of your diagnosis or treatment. Most lawyers taking a malpractice claim on behalf of a patient are totally ignorant of whether the doctor has performed in a medically acceptable fashion or not; they take the case on a contingency fee, and by the time they discover that the doctor, in all probability, was not at fault, they have invested so much in the case that they feel obliged to pursue it to trial. Although this may seem unfair, it is a relatively small price for the benefits of the present system. At the least, don't waste your energy planning your countersuit; plenty of time for that after you prevail as a defendant.

A common problem doctors encounter in dealing with their lawyers is the inability of any lawyer to "diagnose" a case, even after a thorough examination of the client. Modern pre-trial procedures do allow us to see most of the whole of the other side's evidence before trial, and as this develops, the lawyer's opinion emerges. On the day of trial, however, even the best lawyer cannot tell you "What's going to happen?" The twelve strangers picked that day to sit in the jury box constitute an unknown, comparable to having a patient with a completely unique juxtaposition of vital organs, undetectable before the abdomen is opened.

PRACTICING DEFENSIVE MEDICINE

There has been much discussion in the literature concerning the practice of defensive medicine. In talking with doctors, we often find that they expect us to advocate the running of many tests and the calling in of many consultants in order to protect themselves from malpractice claims. This is not necessary.

From the standpoint of the lawyer who would be defending you in the event of a malpractice claim, nothing is required of you as a physician except to practice good medicine as defined by the patient's welfare. This is true because there are no statutes or written directives of any sort stating that, for example, an open reduction must be performed on a certain

type of fracture in order to avoid a charge of negligence. Rather, the evidence is presented to a jury, and they decide, in light of the circumstances as explained by the physician himself and other expert testimony, whether an open reduction were a discretionary decision, in which case no negligence is involved, or whether it were mandatory under the circumstances. The jury must consider all of the circumstances, so that if the patient were a poor surgical risk, for example, in light of our experience with juries, we would not anticipate that the jury would be critical of the physician for adopting a course of conservative treatment rather than one of anesthesia and surgery. Thus, any time a physician's actions, no matter how poor the result, can be justified in light of the doctor's best medical judgment in the interest of the patient, there is a strong defense. This is not to say, however, that there are not some defensive measures which a physician can and should take in anticipation of a malpractice claim.

Such precautions do not deal with an alteration of diagnostic procedures or the selection of treatment. Rather, they deal with such things as keeping accurate records, in order to document what was explained to the patient, what the patient and the patient's family had to say in response, and what symptoms the physician relies upon in making his diagnosis in selection of treatment. This is vastly different from changing the number of tests which are run or the extent of a physical examination; rather, it is important to record all those findings, both positive and negative, on which the physician feels he can confidently base such a diagnosis or selection of treatment.

It also becomes important in many lawsuits to establish that the patient was instructed to return and in fact did not do so; therefore, it is desirable to keep records reflecting either that a return appointment has been made, or, on the patient's chart, that the patient has been instructed to return. These are clerical matters, not affecting the diagnostic or treatment course of the patient, but nonetheless they are often vitally important in the defense of the malpractice claim.

LOOSE TALK SINKS SHIPS

Perhaps the highest duty of the physician in avoiding malpractice claims, both against himself and others, is the avoidance of rash

statements. The general guideline is that a physician, in talking with the patient or family members, or indeed with anyone else, should remain *objective* rather than subjective.

An untold number of lawsuits arise because a physician, commendably disturbed by a poor result, and seeking to console a distraught patient or family member with a concrete explanation, makes some statement as to the cause of the problem which is nothing more than pure speculation on the part of the physician. This is of great legal significance which need not be expanded upon here, but suffice to say that a physician should never offer any explanation with any more certainty than is an actual medical probability. Too often, physicians who are all too aware of the uncertainties of the science of medicine, when confronted with the lay patient or family member, seek to give a "pat" answer which comes back to harm them in court. Often this explanation indicates the physician as being at fault.

Likewise, many physicians have found themselves in a court of law because they angrily deplored a mistake by hospital personnel to the family without knowing whether that failure actually had any causal relationship to the patient's problem; as a result, the hospital is sued, and the doctor joined as a defendant in order that he be pressured into reiterating the damaging statements he made in the past against the hospital personnel. It is of utmost importance that the uncertainties of medicine be outlined to the patient and family from the outset, particularly when a bad result has been obtained.

An even more frequent cause of malpractice suits is the "holier-than-thou" remark made by the physician who sees the patient after the bad result is obtained under the care of a prior treating physician. It is totally amazing the number of physicians who, upon examining a patient who has had less than desirable results from prior treatment, will exclaim, "What butcher did this to you?" "Why in the devil didn't your doctor do such-and-such?" or "Somebody really made a mess out of this!" In almost every instance, the doctor making such a statement has no knowledge of the prior treatment, the problems which may have been confronting the physician who treated the patient previously, or the patient's own noncooperation or failure to follow the prior physician's instructions. If you as a physician are guilty of making such careless remarks without knowl-

edge of the facts, not only may you instigate a lawsuit where none is justified, but you will certainly be called as a witness against a member of your own profession. This may prove extremely embarrassing when you discover that there were extenuating circumstances which render your remark totally unjustified.

This is *not* to say that one physician should never criticize or testify against another physician; it is merely to urge all members of the profession to restrain themselves from passing judgment until all of the facts are in hand. We have actually seen cases in which physicians have made such statements to a patient when in fact, had those physicians made the effort to consult with the prior physician, they would have learned facts which would have rendered their own treatment more effective; some of these subsequent treating physicians have made gross errors because of their failure to learn from a technically accurate medical source the course of the patient's prior disease and treatment.

It is incumbent on any responsible physician not to render any opinions as to cause or judgment as to negligence, unless he feels confident he (1) has all the facts and (2) is certain enough of his opinion to be willing to so testify under oath — because the greatest likelihood is that eventually he will be asked to do just that.

Keep in mind that statements made by you on a chart are just as much potential evidence as oral remarks. Many entries on charts do not rise above just that — mere remarks. This should be avoided, as the fact that the remark is in writing on a chart, that mysterious document unread by lay persons — until trial! — gives the comment added weight. "The doctor would not have written it in the permanent record unless it were so," reasons the lay person on the jury. Impressions, provisional diagnosis, and pure conjecture should be *clearly designated as such on the chart* whenever uncertainties need be recorded. Otherwise you will find yourself explaining from the witness stand that although you know what you *said* (or *wrote*), that's not what you *meant*. Often true, but hard to explain!

Finally, as a general matter, try to be guided by your lawyer. *Don't* try to guide him in legal matters. *Do* try to explain to him, in fullest detail, all medically significant facts. And satisfy yourself that he does understand those facts and their interrelationship. Try to show

A Defendant / SHORT, LAUGHLIN

him the respect as a professional which you demand for yourself. Human nature dictates he will do a better job for you if you do. Above all, remember he is already on your side; don't waste valuable time trying to win his approval, but set about at once the tasks of defending as he prescribes.

SETTLEMENT

There are many reasons your lawyer may recommend settlement, most of them having nothing whatsoever to do with any thought that you were negligent. The trial lawyer must weigh the *probability* of a judgment against you, the range of the amount which would be involved, the time consumed from the doctor's schedule by a trial, and an element unique to malpractice, the doctor's desire to defend on a matter of principle rather than to pay even a small sum.

Note, the lawyers decide the *probable* jury reaction — not what he thinks it *should* be. This is influenced by many factors. Horrible injuries, for example, increase the likelihood that the jury will disregard a plaintiff's weak case on liability. Likewise, a single strong expert for plaintiff, lack of communication with his own defendant, a very appealing plaintiff or a defendant with a negative personality, bias of a judge or community — all may affect the lawyer's decision to recommend settlement even though he believes strongly yours is a case of no liability. Therefore, if he recommends settlement, do not be offended, but rather, ask him to explain (if he fails to volunteer) the factors he considers important *in predicting what a jury will do*. At this point, the medical propriety of your conduct is not the deciding factor. Once you understand his reasons, you may accept or reject his advice, but remember: advice to settle is *not* an expression by your lawyer that he feels you were negligent and liable; it means nothing more than that he thinks a jury might so find.

TRIAL

If you do go to trial, your lawyer will prepare you to testify and will try to tell you what cross-examination to expect. The "other side" always puts their case on first, and may not call every witness they have listed. Therefore, it is impossible for your lawyer to tell you how

long the trial will last or when you'll testify, as you may even be called as part of the plaintiff's case. Don't take this as a lack of organization. You can also help your lawyer by explaining the problem to those doctors who may be testifying in your behalf. Many times we encounter belligerence when we cannot tell a prospective witness a definite hour, or even a certain day! This is impossible to avoid, as we must wait until the plaintiff is through, and we have no control over that.

Do not expect to communicate closely with your lawyer during the actual trial. Events are rapid in a trial; whole strategies may go "down the tubes" with one question and answer, and must be replaced in a matter of seconds. Your lawyer must listen intently, even while feigning inattention. Do not talk to him. Do not take notes or write him notes. Your role is NOT that of the advocate; it is as impassive as possible except when on the stand. You should not appear to participate at all. There is one exception. Rarely, a new medical fact will arise which you have not already explained to your lawyer. You may need to write a note in this instance, but this occasion is rare.

Look to your lawyer for protocol. One must not look at or speak with jurors in a social fashion, nor should one ever converse with *anyone* within hearing of any juror. Do not try to make friends with the jury; it insults their integrity by suggesting they can be swayed from their duty by bias. For the same reason, one *never* thanks a juror for a favorable verdict, nor a judge for a favorable ruling.

Your lawyer may leave you alone a good deal of the time during trial, at recesses, or even at lunch. He may need time to think or plan, or to confer with co-counsel. He may be in chambers arguing legal matters before the judge. He may simply need to clear his head.

At all stages of preparation, settlement, and trial, remember that, in a very real sense, you are the "patient" and your lawyer has assumed the role you usually play. Try to conduct yourself as you would have any patient do—give him your respect and trust, listen well, give him all the information he needs, follow instructions, don't try to do *his* job, or "treat" yourself. Remember that a good patient is easier to heal, and give your cooperation freely. You will substantially enhance your own chances for a "good result." □

3200 Liberty Tower, Oklahoma City, Oklahoma
73102

Malpractice: The National Situation

ED KELSAY

Oklahoma's malpractice situation has been described as "an island of tranquility in a sea of turmoil," by an official of The Insurance Company of North America. This comment came during the research for this article on the national malpractice situation.

The economical availability of professional liability, or malpractice insurance is becoming a daily concern for physicians throughout the United States. According to an AMA report, "premiums paid by physicians, surgeons, dentists and hospitals during 1974 probably amount to \$225,000,000 or more, based on projections from data in the report of the HEW Commission on medical malpractice for the year 1970 and earlier."

For the past several years the major professional liability insurance problem, as seen by most physicians, was the amount of the premium they would have to pay. However, now the problem is becoming whether the coverage will be available at any price.

Insurance magazines are replete with stories about insurance companies abandoning the malpractice market. Fewer and fewer companies are showing interest in filling the void.

A notable example took place in the state of New York. Employers Insurance of Wausau, Wisconsin, announced in late 1973 that it would terminate all of its malpractice coverage in the state of New York as of May 1, 1975. The company had had the New York State Medical Society's endorsement for 25 years.

Twenty thousand New York physicians faced the possibility of being without professional liability coverage. Their total yearly premiums to the company had amounted to \$40 million, but that amount was not enough.

It took NYSMS seven months to locate another company that was willing to underwrite malpractice policies for its members. Argonaut Insurance Company agreed to enter the market provided there was an across-the-board 93.5% hike in annual premiums. This increase will mean that some high risk surgeons will be paying as much as \$14,329 for basic \$1 million-\$3 million coverage.

(Most of the insurance companies writing malpractice policies on the east and west coasts insist on high limits basic coverage of \$1-\$3 million, as opposed to the more traditional coverage of \$100-\$300 thousand.)

Even with the 93.5% premium increase, Argonaut was the low bidder. Some companies had insisted on as much as a 200 - 300% premium hike before they would consider writing in New York.

New York isn't the only state with problems. Several changes in companies writing mal-

practice in California prompted the state's Commissioner of Insurance, Gleeson L. Payne, to say, "I believe we are on the threshold of having no market for malpractice insurance."

About 30,000 doctors in that state pay up to \$25,000 a year in premiums for insurance, premiums that are rapidly increasing because of inflation and a growing number of malpractice claims.

Some doctors in California have suddenly found themselves without insurance. Approximately 2,300 California physicians not only lost their professional liability coverage, but are being assessed additional amounts, up to 90% of their premiums, to insure future claims are paid.

Casualty Indemnity Exchange, a Missouri-based firm writing malpractice coverage in California, found that its 1972 premiums were actually inadequate to cover losses and expenses.

Citing an almost \$3 million deficit, the California Department of Insurance cancelled all of the malpractice policies and ordered the physician policyholders to pay an assessment ranging from \$300 to \$9,000, depending on the amount of coverage, into a special trust account to cover future losses.

Another group of doctors in southern California found themselves changing insurance coverage when their group professional liability carrier, Hartford Insurance, announced it planned to double its premiums. Although they found a new carrier in Travelers, that company insisted on a 30% premium increase plus an increase in the minimum basic limits from \$100 thousand to \$1 million.

Substantial premium increases are the rule all across the country, not just on the east and west coasts. The two companies writing coverage in North Carolina, St. Paul and Aetna, requested an 82% and a 150% increase respectively. New Jersey physicians were faced with an increase from 5% to 200% depending on the class they were in.

Other states showing increases were as follows: Wyoming, 56%; Maryland, 46%, Rhode Island, 65%; Massachusetts, 65%; Wisconsin, 50%; and, Pennsylvania, 59% for Aetna and 44% for Medical Protective.

While Oklahoma physicians are faced with a 20% increase in premium from INA, physicians in the state being underwritten by other

companies may see a 54.2% increase. This is the amount requested by the national insurance rating bureau, known as Insurance Services Office.

According to the AMA report, "medical liability insurance programs sponsored by state or local medical associations now exist in at least 30 states. These programs provide some measure of assurance for continued availability of coverage and realistic cost based on loss experience. They cannot, however, guarantee an end to increasing premiums or complete freedom from problems."

Some states that have not had preferred carriers in the past, now are looking for them. The State Medical Society of Wisconsin undertook such a search after the companies writing professional liability in that state took a get-tough attitude.

St. Paul Fire and Marine Insurance Company in Wisconsin had stopped writing new policies for anesthesiologists, emergency room doctors, gynecologists, orthopedists, and plastic surgeons. In addition, Medical Protective and Aetna Insurance each said they would continue to write new policies only after close scrutiny of each applicant. All of the companies indicated they expected their premiums to increase at least 50%.

The frequency of claims and their dollar value has increased dramatically. According to New York statistics, ten years ago claims averaged four per every 100 physicians insured; but when 1972 litigation is completed, the state estimates there will be 8.3 claims per 100 insured physicians.

St. Paul Fire and Marine published a nationwide summary of pending medical malpractice cases as of March 31, 1974. That

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summary showed that 15.4% of its Class 5 physicians were facing outstanding claims. Each of those claims averaged \$14,623.

As could be expected Class 1 physicians had the least percent of frequency of outstanding claims, 3.7%, but ranked second in severity with an average claim of \$10,705. Frequency for Class 2 physicians was 6.2% with an average of \$9,497 per claim. Class 3 physicians had an average claim of \$11,554, with a frequency of 7.1%. Thirteen and eight-tenths percent of the Class 4 physicians had outstanding claims with an average of \$13,000 each.

According to the AMA report, the situation regarding number of claims may get even worse. The report states, "although the degree of injury varies greatly, it is generally agreed that there are a substantial number of serious injuries which occur at present, but do not develop into claims. Each year, more of these serious injuries do become claims. This results in an increased loss experience and consequential increases in the cost of insurance."

The report points out that it is reasonable to estimate that the annual number of patient visits to physicians and dentists amount to approximately 3.25 billion. Each such patient visit is an exposure to some risk of a medical injury. The report says, "if the average probability of injury were no more than one in ten thousand visits, that would be a lower rate of risk than that found in most human activities, but it would indicate a total annual number of injuries amounting to 322,600." If the rate were one in 1,000 visits, the total number of injuries would be 3.25 million. Either of these figures is much higher than the total number of medical liability claims being made annually at the present time.

The AMA report goes on to note, "...the trend in the courts is in the direction of imposing liability on someone for every injury that occurs. This is true in all kinds of litigation, not only malpractice litigation. It is also only a trend, which has a long way to go before it reaches the point at which every injury is compensated. That is why it is unlikely that the cost of malpractice insurance will level off for some years to come."

Robert J. Miller, a vice-president for Medical Protective Company of Ft. Wayne, Indiana, said, "...the most distressing aspect of today's malpractice situation is a willingness of juries to award large sums of money to a plaintiff and the willingness of the courts to

uphold these verdicts even in the absence of proof the doctor did anything wrong.

"Our society has developed an acute awareness of injured individuals and, it would seem, desires that injuries be compensated irrespective of responsibility."

A report compiled by the St. Paul Fire and Marine Companies across the nation may help explain why juries tend to make large awards in malpractice cases. The report notes that 18% of all medical malpractice injuries result in death, 19% leave permanent effects, and the rest are temporary. In this latter group, 12% cause psychological scars regardless of the physical damage extent.

Lawyers agree that injuries and disfigurements that are obvious to a jury weigh heavily in favor of the plaintiff. Top trial lawyers teach their clients how to "display" their injuries to the best advantage in order to gain sympathy from the jury.

The AMA report ended on a disheartening note by stating, "...until a point is reached at which substantially all potential claims have become actual claims, insurance loss experience is apt to continue to rise every year. Unless appropriate remedial legislation can be enacted in the several states, there does not seem to be any end in sight for the continually increasing cost of medical liability insurance. Under present conditions, however, the best assurance physicians can have for continuing insurance coverage is through a program sponsored by their medical association."

The professional liability situation prompted a memorandum by a company that specializes in reinsurance. Bowes and Company, Inc. of Missouri notified all its clients that they should keep Lloyd's, the large underwriting organization in London, England, in mind for malpractice liability insurance coverage.

The memorandum pointed out, however, that Lloyd's underwriters are looking at each malpractice risk individually and that they will not write hospitals, doctors who are employed by hospitals, anesthesiologists, "and a few other classifications according to specialties and claims experience."

The professional liability situation is best summed up by one sentence in the company's memorandum: "The Lloyd's market is expensive, but in this day and age any market is better than none." □

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Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years of age, and in patients who are jaundiced or sensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children because of variable response, and with extreme caution in patients with cirrhosis and other hepatic disease or abnormal liver function because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturate tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate a hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high doses but does not exceed recommended dosages. Administer with caution to patients receiving addicting drugs known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine added to discourage deliberate overdose; observe contraindications, warnings and precautions for atropine; use with caution in children since atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and tachycardia. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, confusion, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: Lomotil is contraindicated in children less than 2 years old. Use Lomotil liquid for children 2 to 12 years of age: 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 4 times daily; adults, two tablets (5 mg.) t.i.d. or two tablets (5 mg.) q.i.d. or two regular teaspoons (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the hands of children since accidental overdosage may be severe, even fatal, respiratory depression. Symptoms of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, bradycardia and respiratory depression which may develop 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a respiratory antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 0.025 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of 1/2 ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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Physician Involvement in Workmen's Compensation Cases

DICK LYNN

Legal requirements connected with treatment of industrial injuries, with reporting procedures, are outlined. Cooperation between treating physicians and claims people is recommended.

In order to understand the legal requirements imposed on the physician once he accepts a Workmen's Compensation case, it is helpful to have some background concerning the evolution of Workmen's Compensation Laws.

Workmen's Compensation is an outgrowth of the industrial revolution. It is social legislation intended to provide certain benefits to the injured worker once he has met basic requirements. These are: (1) He must have sustained an accidental injury. (2) It must arise out of his employment. (3) It must be during the course of his employment.

Once these basic requirements have been met the employer and its insurance carrier are legally required to provide: (1) medical treatment as defined by statutes; (2) payment of temporary total compensation benefits as a percentage of the average earnings with a maximum limitation, usually by the week; (3) payment for partial or total permanent disability as set out in the schedule of compensation, also with a maximum limitation based on a percentage of average earnings.

Physician involvement in Workmen's Compensation cases obviously is in the area of medical treatment. Each physician should have

available that section of the Workmen's Compensation Act pertaining to medical treatment. Copies of the entire law are available, at a cost of \$2.00 per copy from the State Industrial Court, P.O. Box 53038, State Capitol Station, Oklahoma City, Oklahoma 73105.

In 1973 the Oklahoma Legislature made extensive amendments to the "medical attention" portion of the Workmen's Compensation statutes. That portion of the law, with points of particular interest in italics, now reads as follows:

The employer shall promptly provide for any injured employee such medical, surgical, or other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus as may be necessary after the injury. *The attending physician shall supply the injured employee and the employer with a full examining report of injuries found at the time of examination and proposed treatment, this report to be supplied within seven days after the examination;* also, at the conclusion of the treatment the attending physician shall supply a full report of his treatment to the employer of the injured employee.

The employer's selected physician shall have the right to examine the injured employee. A report of such examination shall be furnished the injured employee within seven days after such examination.

If the employer fails or neglects to provide the same within a reasonable time after knowledge of the injury, the injured employee, during the period of such neglect or failure, may do so at the expense of the employer; provided, however, that the injured employee, or another in his behalf, may obtain emergency treatment at the expense of the employer where such emergency treat-

ment is not provided by the employer. *Notwithstanding any other provision of this section, the employee may select a physician of his choice to render the necessary medical treatment, at the expense of the employer; provided, however, that the attending physician so selected by the employee shall notify the employer and/or the insurance carrier within a reasonable time not to exceed seven days after examination or treatment was first rendered. The term physician as used in this section shall mean any person licensed in Oklahoma as a medical doctor, chiropractor, chiropodist, dentist, osteopathic physician or optometrist. If such injured employee should become deceased, whether or not he has filed a claim, such fact shall not affect liability for medical attention previously rendered, and any person or persons entitled to such benefits may enforce charges therefore as though such employee had survived. . . .*

The remainder of that section deals with payment mechanisms, reasonableness of charges, and enforceability of payments to physicians.

It will be noted that the very first of this quoted section requires that the employer promptly provide such medical, surgical or other attendance or treatment as may be necessary after the injury. Special attention is called to the requirement that "the attending physician shall supply the injured employee and the employer with a full examining report of injuries found at the time of examination and proposed treatment, this report to be supplied within seven days after the examination . . ." The statute then goes on to require that at the conclusion of treatment the attending physician shall supply full report of his treatment to the employer of the injured employee.

The State Industrial Court of Oklahoma has jurisdiction in Workmen's Compensation cases. Certain forms have been designed to be used in the processing of Workmen's Compensation claims. Those with which physicians will have contact are: Form 4, Attending Physician's Report; Form 19, to be used by the physician in case of dispute as to the reasonableness or compensability of his charges; and Order For Medical Examination. The last of these may never be seen, although State Industrial Court occasionally does exercise its

right to direct a claimant to a physician for examination. Other forms, not statutory, which physicians may see are "Surgeon's Report," "Final Report and Bill."

In routine cases physicians will be expected to complete either Form 4 or the Surgeon's Report. Generally these forms are furnished by the insurance carrier and should be returned promptly to the carrier. Since it is the statutory obligation of the employer and insurance carrier to provide medical care, the privileged communication between physician and patient does not exist. However, if an insurance carrier requests any medical information other than that relating to the injury which is being treated as a compensation case, the physician should require a medical information authorization from the patient.

At the conclusion of treatment in a routine case the physician should furnish the "Final Report and Bill" on forms furnished by the insurance carrier. On both forms particular emphasis should be placed on the questions of permanent disability and the date of release to return to work.

In those cases involving obvious permanent disability, the insurance carrier will appreciate immediate notice by telephone, where it is possible, or notice to the employer, so consultation by a specialist may be arranged where indicated.

In cases involving permanent disability, narrative reports are indicated at regular intervals. The question of an additional charge for such reports should be resolved with the insurance company involved. In general, unless the demand of the insurance company for interim reports is excessive, the cost of such reports should be included in the cost of treatment.

At the conclusion of treatment in cases involving partial permanent disability, a narrative report always should be furnished and it

Dick Lynn received his law degree from the Oklahoma City University in 1951. He is currently Staff Attorney for The Hartford Insurance Group. Mr. Lynn is a member of the Oklahoma Bar Association; a Past-President of the Oklahoma City Claim Men Association; a charter member, Past-President, member of the Executive Committee, and currently chairman of the Medical Claims Liaison Committee of Oklahoma Claim Men Association, Inc.

should meet the requirements of Rule 12 of the State Industrial Court. The rule is quoted below:

RULE 12. MEDICAL EVIDENCE BY WRITTEN REPORT

The court favors and encourages the producing of medical evidence by written reports which shall include:

- (a) history
- (b) complaints
- (c) findings on examination (including x-rays if made)
- (d) extent of disability whether temporary or permanent
- (e) cause of disability found
- (f) medical treatment, if any, that may be necessary or recommended
- (g) whether temporary total disability has terminated and date of termination and whether permanent partial disability exists and is ready for evaluation.
- (h) detailed factors and reasons upon which rating of permanent disability is based.

It is a general observation that most problems in human relations result from the lack of, or poor communications. This is equally true in the relationship between the physician

and claim representative of the insurance carrier in a Workmen's Compensation case. Experience indicates that most misunderstandings can be avoided if on the first case of any consequence the physician can make himself available for a short conference with the claim representative. Five minutes or less should suffice in all except cases of extreme severity.

The claim representative is admonished never to appear at the physician's office unannounced. He should make arrangements through the physician's appointment desk and the physician should make an effort to see him promptly at the appointed time. Like the physician, the claim representative has a busy schedule and has many contacts which he must make during the course of any working day.

The Workmen's Compensation Laws are extremely complicated. Claim representatives must be intimately familiar with the ins and outs and quirks of that law. They can be a valuable source of information to physicians and stand ready to answer or find the answer for any question that a physician might have. □

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L. RUSSELL MALINAK, Associate Professor of Obstetrics & Gynecology, Baylor College of Medicine, Houston, Texas

Professional Liability: The Oklahoma Situation

ED KELSAY

Even with a 20% premium increase, Oklahoma physicians have one of the best professional liability insurance situations in the nation today. The nearly 2,000 OSMA members insured by INA pay a lower premium than some of their colleagues right here in the state.

Oklahoma physicians saw a 20% increase in their professional liability premiums effective January 1 of this year. The increase affected nearly 2,000 Oklahoma physicians who carry their professional liability insurance through the Insurance Company of North America's wholly owned subsidiary, Pacific Employers Indemnity Company.

The rate increase, which was approved by the OSMA's Council on Insurance, is only the third in the association's eight-year relationship with INA. While the rule nationwide seems to be yearly increases, Oklahoma physicians have seen only three since 1967, offset by a 10% dividend that was paid during 1968.

The OSMA's relationship with INA began on December 10, 1966, when the association's House of Delegates authorized the Council on Insurance to enter into a contract with INA as the association's preferred professional liability insurance carrier.

That contract has proved to be unique among the nation's many medical societies. It is bene-

ficial to both the insurance carrier and the association.

In return for the OSMA's endorsement of INA as the preferred carrier, the company promises to do several things:

First, the company agrees to furnish promptly the OSMA with a copy of any report or claim or incident reported to it by a physician or surgeon insured under the program. This prompt reporting will allow the association to spot malpractice trends before they become well developed.

The company also agrees to keep the association fully informed on losses, reserves, and the final disposition and payment on any claim.

Another protection included in the contract is an agreement that INA will provide the OSMA with a list of all insured physicians and surgeons at least twice each year. This list will include the physician's name, policy number, policy anniversary date, and limits of professional liability. This certified list is retained at the OSMA office to be used, if necessary, years from now to prove that a physician did, in fact, have professional liability coverage on a certain date.

The company also agrees to notify the OSMA at least ten days before it initiates any action to cancel, reduce limits, or refuse to renew the malpractice insurance of any association member. During that time, the association may object to the action proposed and enter into direct negotiations with the company in order to protect its member.

Other sections of the contract call for the INA to consult with the association before it makes any change in rates, to establish a rate

structure that would be on a statewide basis with no surcharges to be added because of geographical location, legal counsel for the defense of professional liability claims may be recommended by the association, and both parties agree to give at least six months notice prior to the proposed cancellation of the relationship.

In return for all of these guarantees by the company, the OSMA agrees to cooperate fully in the processing of professional liability claims and to supply, if needed, expert guidance to INA regarding the medical merit of a claim.

In addition to endorsing INA as the professional liability carrier of choice, the association also agreed to provide all reasonable assistance in promoting physician-enrollment in the program.

One of the last provisions in the contract is that the OSMA agrees, "when requested by INA, to support INA in filing for appropriate rate changes after consultation between the parties has been had and both parties agree that a change in the rates (either up or down) is warranted under the circumstances." This is exactly what happened last summer when the OSMA Council on Insurance met with INA representatives to work out the 20% premium increase for 1975.

Based on the general economic situation in the country and the Oklahoma loss experience, the Council notified the Oklahoma Commissioner of Insurance that they concurred in the premium increase being sought by INA's Pacific Employers Indemnity Company.

If that rate increase had stood alone, without any increase by other companies selling the same type of insurance in Oklahoma, the INA rate would still have been well below the so-called bureau rate for all physician classes in the state. As an example, the INA rate plus the 20% premium increase would be \$203 for a Class 1 physician. That same physician, purchasing identical coverage from a bureau company, would pay \$297.

Within 15 days after the date the INA proposed its 20% premium increase to the State Board of Property and Casualty Rates, the Insurance Services Office (ISO), the new name for the old Insurance Rating Bureau, applied for a 60% premium increase for its member companies. This means that the Class 1 physician purchasing his coverage from a company other than INA could pay as much as \$475 for

coverage that could be purchased for \$203 under INA's new rate.

If the Insurance Services Office premium rates are accepted by the Insurance Commission, Oklahoma physicians insured through those companies may be paying as much as 150% more than their colleagues insured through INA.

Another change that is being made across the nation is in the classification of physicians. INA is currently using five classes of risk. Some companies are now proposing twelve classifications, and there are indications that ISO may seek such a change for its companies doing business in Oklahoma.

The five classifications currently being used by INA are as follows:

Class 1 physicians are general practitioners and specialists who do not perform obstetrical procedures or surgery, other than incision of boils and superficial abscesses or suturing of skin and superficial fascia, and who do not ordinarily assist in surgical procedures.

Class 2 applies to general practitioners and specialists who perform minor surgery, including obstetrical procedures not constituting major surgery, or who assist in major surgery on their own patients. For purposes of this classification, tonsillectomies, adenoidectomies, and Caesarean sections shall be considered major surgery.

Class 3 includes specialists and general practitioners who perform surgery or assist in major surgery on other than their own patients.

Class 4 includes cardiac surgeons, otolaryngologists not doing plastic surgery, general surgeons, thoracic surgeons, urologists and vascular surgeons.

Ed Kelsay was graduated from the Oklahoma City University School of Law in 1967. He is presently Associate Executive Director of the Oklahoma State Medical Association; Adjunct Professor of Medical Law and Ethics, Oklahoma University School of Allied Health Manpower, Oklahoma City; and Visiting Lecturer on Medical Law, Oklahoma University School of Medicine. Professional organizations of which he is a member include the American Bar Association, Oklahoma State Bar Association, Oklahoma County Bar Association, the American Association of Medical Society Executives and Associate-in-law member of the American College of Legal Medicine.

Class 5 physicians are those practicing in the specialties with the highest medical-legal risk. These include anesthesiologists, neurosurgeons, obstetricians, gynecologists, orthopedists, otolaryngologists doing plastic surgery, and plastic surgeons.

As of December 31, 1973, Oklahoma physicians had paid \$4,226,746 in premiums since the program began in 1967. Actuaries working for the insurance company estimate that ultimate losses will reach \$3,625,277 at some point in the future. However, the total loss grows worse with each additional year of experience.

The major problem insurance companies have in figuring professional liability premiums is what is known as "lag time." This is the period between the time an injury occurs and the time the claim is finally settled.

This "lag time" problem has been increasing in the past few years. While Oklahoma physicians paid \$1,152,319 in premiums during 1973, INA estimates that its ultimate loss on that year will be \$1,520,988. Slowly but surely over the past eight years the amount of ultimate loss to be insured has been creeping up on the amount of earned premium. It was only in 1973 that the projected loss exceeded the earned premium amount.

Although there is a statute of limitations in Oklahoma law, it does not begin to run until the patient knows, or should know, that he was injured. In situations where pieces of surgical apparatus are left inside the body, the patient may not discover their presence for many years. While an injury may occur today, it may not become an active claim for 10 to 20 years. There is one case in Oklahoma in which the lag time was 21 years between the date of injury and the final settlement of the claim.

In its report to the 1974 OSMA House of Delegates the Council on Insurance stated,

It is hoped that the premium cost can be held relatively stable in the coming years, but we must all recognize that malpractice claims and awards are on an upswing across the nation. While we have been favored by a better malpractice climate than other states, the number of claims and the amount of the dollar demands are continuing to rise in Oklahoma.

The Council on Insurance will undertake various claims prevention programs during the coming year in order to help stabilize our position as much as possible. We have an excellent working relationship with the Insurance Company of North America, and while it is entirely possible that we cannot continue to hold a stable premium in the face of increasing threats, we are satisfied that INA will continue to provide a market for us at the best possible rates dictated by the circumstances.

This article and other articles in this issue of the OSMA Journal are a part of the Council's Claims Prevention Program. One of its long term projects is the continuing availability of the OSMA Professional Liability Manual for physicians. This was originally published in 1968 and copies are still available from the OSMA office. The manual contains information on doctrines of law that are of importance to physicians, pointers on how to avoid malpractice situations, and a series of forms and suggested letters to be used in medical practice.

One or more copies of the manual are available upon request to the OSMA office in Oklahoma City. □

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OKLAHOMA MEDICAL SUMMIT '75

April 23rd-26th, 1975—Lincoln Plaza Forum—Oklahoma City

A combined meeting of the Oklahoma State Medical Association, the Oklahoma City Clinical Society and the Oklahoma Academy of Family Physicians.



News From The Oklahoma State Department of Health

ANTIRABIES TREATMENT

As spring approaches animal rabies is on the increase again in Oklahoma. A review of human antirabies prophylaxis is in order. The following recommendations can be modified according to knowledge of the species of the biting animal, circumstances surrounding the bite incident, and vaccination status of the animal.

Ideally, post exposure rabies prophylaxis should include:

1. Thorough flushing and cleansing into the wound with soap solution. Quaternary ammonium compounds may also be used (remove all soap since soap neutralizes activity of quaternary ammonium compounds);

2. If the biting animal is rabid, has disappeared or is a wild carnivore, antirabies serum

is indicated. The recommended dose of antirabies serum is 40 I U/kg (1 vial / 55 pounds). Up to 50% of the antiserum should be used to thoroughly infiltrate the wound and the rest administered intramuscularly. Tests for hypersensitivity *must* be performed unless human origin rabies immune globulin (HRIG) is used. HRIG is in very short supply and should be used only in persons hypersensitive to equine serum;

3. Duck Embryo Rabies Vaccine should then be administered. Twenty-one doses (two per day for seven days and one per day for an additional seven days) are the recommended *primary series* when antiserum or HRIG are used. Three booster doses of vaccine are also recommended at 10, 20 and 90 days after the completion of the *primary series*;

4. All patients should have serum tested for neutralizing antibody three-four weeks after the last booster;

5. Tetanus prophylaxis and bacterial infection control as indicated. ☐

REFERENCES:

1. PHS Advisory Committee on Immunization Practices
2. WHO Expert Committee on Rabies, Sixth Report

COMMUNICABLE DISEASES IN OKLAHOMA FOR JANUARY, 1975

DISEASE	January 1975	January 1974	December 1974	Total To Date	
				1975	1974
Amebiasis	1	2	2	2	2
Brucellosis	1	—	2	1	—
Chickenpox	125	44	161	187	44
Encephalitis, Infectious	2	3	3	2	3
Gonorrhea (Use Form ODH-228)	998	878	1113	998	878
Hepatitis, A, B, Unspecified	100	80	49	119	80
Leptospirosis	—	—	—	—	—
Malaria	—	—	—	—	—
Meningococcal Infections	2	4	1	2	4
Meningitis, Aseptic	5	1	2	5	1
Mumps	17	23	12	21	23
Rabies in Animals	12	8	10	14	8
Rheumatic Fever	1	2	—	1	2
Rocky Mountain Spotted Fever	1	—	4	1	—
Rubella	42	10	—	44	10
Rubella, Congenital Syndrome	—	1	—	—	1
Rubeola	1	3	1	1	3
Salmonellosis	22	13	13	24	13
Shigellosis	103	12	17	106	12
Syphilis, Infectious (Use Form ODH-228)	13	15	21	13	15
Tetanus	—	—	—	—	—
Tuberculosis, New Active	17	21	12	25	21
Tularemia	—	—	—	—	—
Typhoid Fever	—	—	—	—	—
Whooping Cough	—	1	1	—	1

Oklahoma Medical Summit To Be "Biggest and Best"

Members of the committee planning Oklahoma Medical Summit '75 have declared that it should be the "biggest and best" medical meeting ever held in Oklahoma. Summit, the combined annual meeting of The Oklahoma State Medical Association, Oklahoma Academy of Family Physicians, and the Oklahoma City Clinical Society, is expected to draw over 3,000 persons.

Scheduled for April 23rd-26th in Oklahoma City's beautiful Lincoln Plaza Hotel, Summit will feature over 50 hours of continuing medical education for physicians and allied health care personnel. Nearly 100 scientific, medical and pharmaceutical exhibits will be available for viewing. Wet clinics will be offered each day featuring actual "how to" demonstrations.

In addition to the three sponsoring organizations, many medical specialty and allied medical organizations are participating in the program.

Three "superstar" luncheons are planned. The first will be held Thursday noon, April 24th, and will feature a presentation by Herb Holden, MD, President of the American Academy of Family Physicians. Friday's speaker will be Phil Thorek, MD, one of the nation's most sought after physician-speakers. Malcolm Todd, MD, President of the American Medical Association will be Saturday's speaker.

Two other programs featuring "superstars" will be held during Summit. On Friday morning Doctor Phil Thorek and William Thurman, MD, new provost for the Oklahoma University Health Sciences Center will speak. A Saturday afternoon program tentatively features Governor David Boren and Henry Simmons, the Director of the Professional Standards Review Office in Washington, DC.

Scientific programs of interest to all physicians will be offered each day during Summit. At the same time, programs of specific interest to medical specialties will be offered.

Programs on Thursday include a special section on Immunology, Allergy, Obstetrics and

Gynecology, Pediatrics, and Surgery. Programs for allied health care personnel will include those presented by the Nurses Association of the American College of Obstetricians and Gynecologists, the Oklahoma State Nurses Association, the Medical Records Association and the Occupational Therapists.

Friday's Scientific Program for physicians will include a full-day session on Cancer sponsored by the Oklahoma Cancer Society. The Heart Association will sponsor a half-day session, as will the Psychiatrists, Ophthalmologists, Otolaryngologists, and Pathologists. Allied health programs will be offered by the Nurses Association, Dietitians Association, Cytopathologists, Physicians Assistants and the Medical Records Association.

On Saturday the emphasis will be on socioeconomics for physicians. However, scientific programs will be offered on Arthritis, Orthopedics, Urology, and Anesthesiology. A special half-day seminar on Hyperlipidemia will be sponsored by the Oklahoma Medical Research Foundation. In addition, there will be a special half-day program planned by the medical students.

Saturday's program for allied health care personnel will include sections on Cytopathology, Operating Room Nurses, and Physicians Assistants.

Three continuing programs will be offered throughout Summit '75. The Tulsa Cancer Society will sponsor an exhibit and a proctoscopic clinic for three days. In addition, the Part B Medicare Carrier for Oklahoma, Aetna, will sponsor a three-day workshop for physicians and their employees on the processing and handling of Medicare claims. A special two-day seminar, with a limited enrollment of 40 physicians, is being offered by the Smith, Kline and French Public Speaking Team. In two full-days the 40 enrollees will receive the equivalent of a full semester's course in Public Speaking.

The social side has not been forgotten. The

first social function during Summit '75 will be the Early Bird Party, Wednesday evening, April 23rd. The party will start with a cocktail reception in the Lincoln Plaza Congress Room and will then adjourn to the Plaza Playhouse for dinner and a play. The evening will be casual and dinner will be barbeque.

Although Thursday evening is open, there will be an early Keg and Oyster and Wine and Cheese Tasting Party starting about 5:00 pm. The Keg and Oyster Party is being sponsored by Marion Laboratories. The Wine and Cheese Tasting is designed to accommodate those with a refined pallet.

Thursday evening will then be open for specialty societies or alumni association dinners. Such a dinner is already being planned by the alumni of the Oklahoma University Medical School.

Friday evening will feature the Presidents' Inaugural Dinner-Dance, honoring the three incoming and outgoing presidents of the sponsoring organizations. It will start at 6:30 pm with a cocktail reception in the Congress Room and will then adjourn to the Plaza Playhouse for a gourmet dinner. (The play will not be offered). A dance will start at 8:30 promptly.

Tickets for the Early Bird Party must be ordered in advance. They are \$25 per couple, \$12.50 per person, and include the social hour, dinner and the theater. Tickets for the Presidents' Dinner will be \$30 per couple, all inclusive, with exception of after dinner drinks, during the dance. Tickets for the luncheons each day will be \$5.00 each. □

New Address For Oklahoma Narcotics and Drugs Commission

Oklahoma's Office of Narcotics and Dangerous Drugs Control has been moved to Room 680 in the Jim Thorpe Office Building in the State Capitol complex in Oklahoma City.

The new mailing address for the commissioner is P.O. Box 53344, State Capitol Station, Oklahoma City, Oklahoma 73105.

The office of the commissioner is the agency which issues Oklahoma physicians their narcotics and controlled substances permits. The commission is a part of the Attorney General's office, however, it has a separate law that controls it.

The Jim Thorpe Office Building is located to the south and west of the State Capitol Building in the State Capitol complex. □

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National Malpractice Situation Deteriorating

While Oklahoma physicians are enjoying no difficulty with their professional liability insurance programs, the national picture is bleak and deteriorating rapidly. Many physicians throughout the country find it impossible to purchase malpractice coverage at any price.

Professional liability is heating up as a key issue in Congress this year. Among the several professional liability proposals being introduced, the most recent is by Senator Kennedy of Massachusetts.

Kennedy's proposal, the National Medical Malpractice Insurance and Arbitration Act of 1975, would authorize the Secretary of HEW to contract with "providers of health care services" who choose to participate in the program. The providers would pay an annual premium to a medical malpractice firm and would receive federal medical malpractice coverage. In return for participation, providers would be required to comply with state license and relicensure requirements which meet or exceed minimum standards established by the Secretary of HEW.

Participating physicians would also agree to accept review of their services by PSRO's, to accept as payment in full for Medicare cases the level of payment established by the federal government and to obtain concurring opinions from a specialist prior to performance of surgical procedures.

The Kennedy bill also would require malpractice claimants and medical care providers to submit medical malpractice disputes to non-binding arbitration. The claimant could either accept the decision of the Arbitration Panel or institute court actions. The decision of the Arbitration Panel, however, would be admissible as evidence in court.

Senate Bill 188, by Senator Gaylord Nelson of Wisconsin, would authorize the Health, Education, and Welfare Department to set up a reinsurance program and to conduct studies and experiments in professional liability coverage.

Representative James Hastings of New York, a member of the House Health Subcommittee, announced that a National Conference on Medical Malpractice Insurance would be held in Washington, DC, March 20th-21st. The two-day conference was arranged by Hast-

ings and the American Group Practice Association.

While Congressional interest was increasing, a number of professional liability insurance companies announced they were either leaving the field, or making drastic changes in their plans.

The St. Paul Fire and Marine Insurance Company, one of the nation's largest professional liability writers, announced that it was beginning to write all policies on a "claims-made" contract basis. Shortly after the announcement, the *American Medical News* reported that "reaction to the news by members of the medical and insurance professions has varied from intense opposition to cautious endorsement. None viewed the action as anything more than a temporary solution to a vast problem. Some, fearing it will become a trend, saw it as a real danger to the practice of medicine."

The company explains "claims-made" in the following way: "Claims-made is a professional liability policy that provides coverage for claims reported to (the company) during the 12-month term of the policy. Next year's claims are covered by next year's policy. Professional services covered are those rendered during the policy period or any previous periods during which the doctor was insured by (the company) under a claims-made policy."

In their company publication, *Malpractice Digest*, St. Paul offered this example of how claims-made would work: Until 1975 Doctor X has been insured under an occurrence contract. Thus, claims reported anytime resulting from professional acts rendered up to 1975 are covered under those occurrence policies.

"On March 1st, 1975, the doctor buys the St. Paul's Claims-made Policy. Any claims reported from March 1st, 1975, to March 1st, 1976, that resulted from a professional act rendered during that period would be covered. It is not necessary the claims be settled before March 1st, 1976, only that the claim (or an incident the doctor has reason to believe may lead to a claim) be reported by that date.

"As time goes on, Doctor X continues to carry claims-made coverage. The retroactive date remains March 1st, 1975. Any claims reported resulting from a professional act on or after March 1st, 1975, will be covered by the claims-made policy in force (in the year) when the claim is made."

As long as a physician keeps the claims-made policy in force he is protected against all claims. The major disadvantage to the individual physician in this new type of professional liability coverage is that he must continue to carry the policy even after he terminates his practice of medicine. If he moves out of the state where the policy is written, becomes disabled, retires or otherwise interrupts his practice, he will be forced to continue carrying coverage in the state where he originally purchased the claims-made policy.

On another front, the American Medical Association has prepared and distributed a package of proposed remedial legislation aimed at resolving the malpractice problem. The package has been distributed to all medical associations by the AMA's Office of General Council.

The suggested legislative approaches are in line with the AMA Board of Trustees three-point Statement on Professional Liability issued in January.

The *American Medical News* reported the following actions being called for by the AMA Board:

"Establishment of a voluntary joint underwriters association in each state to spread the risk of insurance coverage among all liability carriers.

"Passage of bills to limit awards for pain and suffering, place a ceiling on awards, shorten statutes of limitations, seek sliding contingency fee scales, limit the guaranty of medical results to assurances set forth in writing, and to eliminate injury alone as a basis of negligence.

"Creation, with the cooperative effort of the AMA and other groups, of a workmen's compensation type of program."

The OSMA's Legislative Committee is studying the recommendations from the AMA's Office of General Council to determine if any of them are applicable to Oklahoma's present situation.

While the professional liability situation was of grave concern to the medical profession, it was of no real concern to the general public. However, when physicians began to threaten to quit practicing medicine because of the high cost of professional liability insurance, it became a public crisis. Newspapers throughout the United States have reported on and then editorialized about the malpractice situation.

While concern is high, and numerous "solutions" are being offered, many physicians and lawyers who have studied the situation are urging that "... we proceed with great caution. This is truly a case where the cure may be worse than the disease."

It has been pointed out by observers that this problem revolves around two of the world's great professions, medicine and law. Tampering with either, and especially with both, can have far reaching consequences. □

Hawaii Tour In November Filling Rapidly

The OSMA tour to Hawaii set for next November is already filling rapidly. The tour will correspond with the AMA's 1975 Clinical Session in Honolulu November 30th-December 5th, 1975. It gives physicians an opportunity to combine business and pleasure.

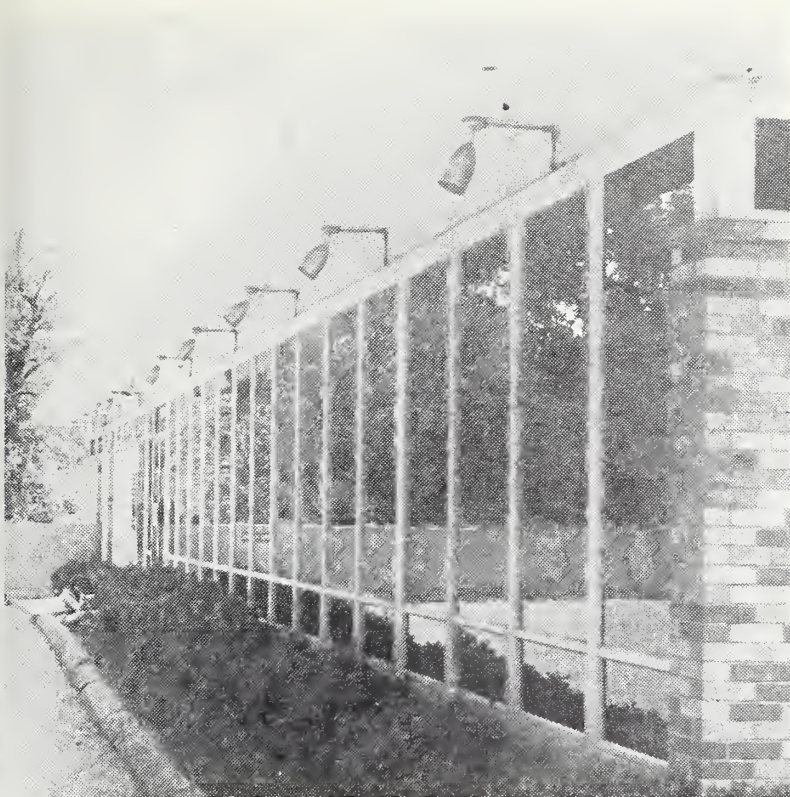
The OSMA's tour will leave Oklahoma City November 28th and return December 7th. It will feature ten days and nine nights including seven nights of superior room accommodations at the beautiful Hawaii Regent Hotel on Waikiki and two nights at the magnificent Maui Surf Hotel on the valley island of Maui. Package price is \$595 per person for a deluxe room accommodation (double occupancy) or \$575 for a superior room accommodation (double occupancy).

An optional tour, in place of the two nights at the Maui Surf Hotel, is available for a \$51 surcharge to the Mauna Kea Hotel, considered to be one of the most luxurious in the world. It is located on the "big" island of Hawaii.

The tour price includes round-trip jet economy airfare from Oklahoma City to Honolulu via Braniff 747 and the inter-island airfare necessary for the two-day side trip. All baggage handling tips on arrival and departure in Honolulu and Maui are covered along with hotel portage and the constant availability of an experienced tour guide or director to assist travelers.

A \$75 deposit per person is required to hold places on the tour. Persons interested should send their reservations to the Oklahoma State Medical Association, 601 Northwest Expressway, Oklahoma City, Oklahoma 73118, attention: Don Blair.

A color brochure describing the OSMA tour is being distributed to all Oklahoma physicians. □



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Utilization Review Regulations Stir Controversy and Concern

New regulations requiring certification of all Medicare and Medicaid hospital admissions within 24 hours became effective February 1st. Published by the Health, Education, and Welfare Department in early December, the new regulations immediately drew opposition from small hospitals throughout the United States, and especially in Oklahoma.

All Medicare and Medicaid hospital admissions are to be certified as medically necessary within one working day of the initial admission and assigned a target length of stay. This length of stay is to be based on the fiftieth percentile of average length of stay by diagnosis and patient age.

The initial certification may be done by a lay person known as a nurse coordinator, patient care coordinator, or Utilization Review Coordinator. This person, working from a set of criteria or guidelines developed by each hospital, may certify an admission as medically necessary if the admitting documents contain sufficient justification. In the event there is not enough information, the coordinator must take the questioned admission to the Chairman of the Utilization Review Committee, or his designee, for a determination.

The coordinator may not deny a certification, they can only certify. Denial of certification can only be done by a physician.

In the event that an admission is denied by the Utilization Review physician, then the admitting physician may appeal to the Utilization Review Committee.

At the present time Oklahoma has over 50 hospitals with four or fewer physicians on the staffs. These hospitals are concerned that it would be "numerically" impossible for them to meet the requirements of the new Utilization Review Regulations. The regulations require that the physician-reviewers must be disinterested in the case. In the smaller hospitals, this requirement would eliminate almost every physician on the staff. It is not uncommon, in smaller communities, for each physician to be covering for every other physician.

Because of the possibility that the new Utilization Review Regulations could result in

the smaller hospitals being eliminated from payment by Medicare and Medicaid, numerous protests began to be heard throughout the United States. In Oklahoma, medical and farm groups, chambers of commerce, and other interested organizations began to complain to their congressmen and to HEW.

Representatives David Craighead of Midwest City and Tom Stephenson of Watonga conducted a public hearing on the problem at the Oklahoma State Capitol Building February 19th. Another hearing was conducted the following Friday in the Federal Building in Oklahoma City by United States Senators Bartlett and Bellmon.

Numerous persons testified at both hearings to the effect that the small hospitals could not meet the new Utilization Review requirements. Not only was there difficulty in providing the appropriate number of "disinterested" physicians, there was also a problem in finding a registered nurse to serve as the coordinator. Many of the small hospitals throughout the state cannot procure enough registered nurses to meet the requirements of the hospital licensure laws. The new Utilization Review Regulations, although not specifying a registered nurse, have such stringent requirements on the coordinator as to almost require that it be such a licensed person.

Aside from the problem of finding an appropriate person to serve as a coordinator, the small hospitals pointed out that this required adding a whole new position to their hospital staff, thus increasing their cost of doing business.

In each of the hearings the Oklahoma State Medical Association testified to the effect that they did not like the new regulations, but would work with the hospitals to see if it was possible to implement them. In the event implementation was not possible, the OSMA proposed that small hospitals, those with active staffs of only a few physicians, be granted a waiver by the Secretary of HEW and then required to follow guidelines similar to the old Utilization Review requirements. The net effect would require the small hospitals to do respective review, as opposed to concurrent review and certification.

In order to assist the small hospitals, the OSMA, through its Oklahoma Foundation For Peer Review, Inc., had established a Task Force on the new Utilization Review Regula-

tions. The Task Force consisted of representatives from the OSMA, Oklahoma Osteopathic Association, Oklahoma Nursing Home Association, Oklahoma Hospital Association, the Licensing Division of the State Health Department, the Part A Carrier, Part B Carrier, and the Welfare Department. The Task Force purpose was to keep each organization as informed as possible on the changing situation regarding the new regulations. In addition, the Task Force sponsored a series of five workshops to assist hospitals in implementing, if possible, the UR Regulations.

The five workshops were held in McAlester, Tulsa, Oklahoma City, Alva, and Altus. Each workshop lasted a full-day and covered topics such as the new Utilization Review Plan Requirements for Hospitals, the Utilization Review Procedure Manual, and what Medicare and Medicaid expected from the Utilization Review Committees.

For its part, the OSMA, through the Oklahoma Foundation for Peer Review, Inc., published a "Guidelines For Hospital Care" handbook. The handbook contains information on admission criteria and length of stay. It was immediately distributed to all Medicare cer-

tified hospitals in the state of Oklahoma.

The handbook contains admitting criteria and length of stay information on 106 admitting diagnoses. Under each diagnosis is also listed the most common reasons for possible extensions of lengths of stay.

The criteria length of stay were adopted by the Oklahoma Foundation For Peer Review, Inc., from those developed and published by the Mississippi State Medical Association and the Mississippi Regional Medical Program. The lengths of stay listed in the handbook are based on the Professional Activities Study, PAS, statistics for southern states.

The foreword to the handbook states that the guidelines, in no way. . ."represent a mandatory pattern of practice to which all physicians must conform. They are general guidelines. In any specific case, a physician may deviate from them on the basis of his professional judgment. Such deviation does not necessarily imply inadequate medical care."

The foundation will conduct periodic reviews and revisions of the handbook to insure that the criteria and length of stay information reflect existing medical skills, knowledge, and quality hospital care in Oklahoma. □



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National Health Insurance Guidelines Issued By AMA

Guidelines or principles regarding National Health Insurance have been endorsed by the Board of Trustees of the American Medical Association. The guidelines were given the widest possible distribution.

They were adopted by the AMA's Board of Trustees during its regular meeting in Chicago on October 25th — 26th, 1974. The same guidelines were reiterated during the AMA's Clinical Meeting in Portland, Oregon in late November and early December.

Fourteen points are included in the guidelines to cover those areas that the AMA feels are essential for National Health Insurance.

The very first point best sums up the AMA's entire position: "Minimum federal involvement in administration of any National Health Insurance Program."

The guidelines go on as follows:

(2) State jurisdiction with respect to licensure and certification of professional health personnel and regulation of insurance.

(3) Minimum federal dollars in financing of

programs for comprehensive coverage at least possible costs.

(4) Funding through federal, state and private funds including employer-employee contributions for private health insurance and an individual tax credit as applied for full health care protection.

(5) No added Social Security tax for financing.

(6) No administration by Social Security.

(7) Cost sharing by participating individuals and families and a subsidy for the indigent scaled according to income.

(8) Use of private insurance on risks and underwriting basis.

(9) Comprehensive coverage, basic and catastrophic, for the entire population.

(10) Pluralism in methods of health care delivery.

(11) Cost controls as appropriate.

(12) Quality controls as appropriate.

(13) Continuity of benefits.

(14) Coordination of benefits.

The fourteen points establish both the minimums and the maximums that the AMA feel are necessary in any National Health Insurance Program. ☐

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Balkan Tour Combines Business and Pleasure

A two-week tour to the Balkan's offers Oklahoma physicians an opportunity to combine business and pleasure. The tour, being sponsored by the Oklahoma State Medical Association, offers two weeks in Bucharest, Istanbul, and Dubrovnik. It will depart Oklahoma City July 19th.

The cost of this non-regimented, luxury trip, which includes direct flights on chartered jets, accommodations at deluxe hotels, complete American breakfasts and gourmet dinners at a choice of the finest restaurants, is only \$1,128 per person.

Arrangements for the trip have been made for the OSMA by INTRAV, the travel company that has spent years developing deluxe personalized vacations at charter cost savings.

Exclusive features of the Balkan tour include VIP pre-registration at all hotels; expedited customs formalities; a generous 70 pound baggage allowance; a travel director and five hosts in each city to assist the traveler; optional sightseeing tours; optional side trips to Kiev in Russia and Izmir in Turkey; and plenty of time for shopping and relaxing.

Combined with the fun of the trip will be a medical seminar for all physicians. The seminars will be conducted in each of the three major cities on the tour. Upon completion of the seminars, a Certificate of Attendance will be issued to each participating physician. The certificate will show an outline of all meetings held with names of lecturers, and topics discussed.

During the Bucharest seminar topics will include Health Care Delivery Services in Rumania, Administrative Problems Related to Old Age, Obstetrical Emergencies, and Eutrophic Therapy In Geriatrics-Therapy With Procainegervital H-3.

Topics for Istanbul include Abdominal Surgery and Peripheral Vascular Diseases, New Methods in Cardiovascular Research, Gynecological and Obstetrical Care in Istanbul, Population Planning Activities, Major Orthopedic Problems in Turkey, Private Practice and Health Care in Turkey, and Neurophysiology and Clinical Electroencephalography.

During the Dubrovnik stay topics will include discussions on Radiology, Prevalence of Rickettsial Disease Incidence of Viral Hepati-

tis, Curative Aspects of Medicine, Narcotic and Non-narcotic Analgesics, Isolated Organs with their Nerves as Tools in Experimental Medicine, and Gastrointestinal Medicine.

The faculty for each of the seminars is made up of physicians from the country being visited and acknowledged experts from the United States. Members of the faculties have been carefully selected in each country to provide interesting information. Registration for the Medical Seminar is \$45 per person.

Mixed with the business of the seminar, of course, is the fun of travel. Bargain hunters will find a wealth of trinkets and treasures; antiques, wood carvings, jewelry, embroideries, copper and brass lamps and kettles, Bursa silks, leathers, hubbly-bubbly pipes and Oriental rugs.

Mosques and cathedrals, museums and art galleries, sun and sea, are there to be discovered. Tastefully prepared foreign foods are in abundance. Try Sarmale, a Rumanian dish of spicy meat wrapped in cabbage leaves, or the Turkish shish kebob with a glass of beer.

In Yugoslavia one whole island, dominated by a Benedictine Abbey, has been converted for tourist entertainment. Dinner in the Abbey itself is considered a gourmet delight.

Persons wishing to register for the Balkan tour should contact the Oklahoma State Medical Association, 601 Northwest Expressway, Oklahoma City, Oklahoma 73118. A \$100 per person deposit is required. □

Health Benefits for the Unemployed

Although President Ford urges no new federal spending programs, interest in providing health benefits for the unemployed has generated several congressional proposals.

The first proposal was introduced by Senator Bentsen of Texas. Citing rising unemployment rates, he called for the temporary extension of Part A Medicare benefits to unemployed workers currently entitled to unemployment benefits. Under his proposal, Senate Bill 496, hospital benefits would also be provided to a dependent spouse or dependent child of an unemployed worker.

In commenting upon the introduction of his bill, Bentsen noted that some 6.5 million men and women are now out of work and that government estimates indicate that more than 1.74 million workers have lost their

hospitalization coverage since December of 1973.

Bentsen estimates that the 12-month cost of his program would be \$2.1 billion. General revenues would be appropriated to the Part A Trust Fund to pay for the temporary hospitalization insurance program, and existing Medicare deductibles and co-payments would be applicable to newly covered individuals.

Bentsen's bill had barely gotten warm before Senator Kennedy got in the act. He rushed in to introduce Senate Bill 625, the Emergency Unemployment Health Benefits Act of 1975.

Kennedy's measure would amend the Emergency Jobs and Unemployment Assistance Act of 1974 so that unemployed individuals entitled to benefits under state or federal unemployment plans would have their health insurance premiums paid by the federal government.

Under the Kennedy proposal unemployed individuals would be entitled to health insurance benefits of the type and scope which they would have received under their previous employment agreement. The Secretary of Labor would make arrangements to pay insurance carriers or other appropriate parties for the continuation of the unemployed workers health insurance. State unemployment compensation agencies would certify individuals as being eligible for health insurance benefits.

Cost estimates on the Kennedy proposal range between \$1 and \$1.5 billion assuming an unemployment rate of 8 per cent. The program would expire on June 30th, 1976.

Both Senators Bentsen and Kennedy, in commenting on their new bills, called for early adoption of a Comprehensive National Health Insurance Program. □

St. John's Hospital Offers Expanded Medical Education Program

An expanded program of medical education available to interested paramedical personnel, as well as licensed physicians, has been scheduled by St. John's Hospital in Tulsa. Eight sessions per year have been set up by the hospital's Department of Continuing Medical Education, under the direction of Bryce O.

Bliss, MD. Each session is sponsored by a different section of the hospital's medical staff.

The first session was held February 10th and was on the subject of joint replacement surgery. The second program in the series was March 10th and stressed the subject of cardiovascular disease.

Announcement of the expansion of the hospital's educational service was made at St. John's General Staff meeting held in January. R. E. McDowell, MD, Chief of Staff, stated, "This the first time this interchange of knowledge on updated procedures and treatment for particular specialties has been made available regularly to all other interested medical and allied personnel throughout the area on such a wide scale. We urge support of this program, and believe it will serve to keep the Tulsa medical community informed as to the latest procedures in the various specialties."

Personnel throughout northeastern Oklahoma and neighboring states are invited to attend the meetings, which will be held in St. John's Hospital School of Nursing Auditorium from 7:30 to 9:30 pm. Free parking is available for attendees in the adjoining 19th Street parkade.

Future programs and topics to be covered and dates scheduled are: April 14th, Cancer Treatment; June 9th, Medicine; July 14th, Pediatrics; August 11th, Ophthalmology; October 13th, Pathology; and December 8th, Surgery.

The success of the first two programs have encouraged the hospital to begin planning for the 1976 sessions. They have already scheduled sessions on Anesthesiology, Radiotherapy, Ob-Gyn, Dermatology, Psychiatry, ENT, Emergency Room Procedures, and Urology. □

Mark Your Calendar Now! Oklahoma Medical Summit '75

**April 23rd-26th, 1975
Lincoln Plaza Forum
Oklahoma City**

Book Reviews

Spinal Dysraphism. Spina Bifida Occulta. By C. C. Michael James and L. P. Lassman, 144 pp, Appleton-Century-Crofts, London, 1972.

This monograph deals with those congenital malformations of the neural tube which are hidden and quite unlike the more familiar myelomeningocele. They include dermal sinus, dermoid cyst, intraspinal lipoma, and diastematomyelia. A detailed description is provided of the embryology, pathology, clinical presentation, radiologic findings and therapeutic principles. Two-thirds of the book is devoted to analysis of 100 cases which provides the reader with a good idea of the range of abnormalities.

This monograph is concerned almost exclusively with the author's own experience and makes little reference to the work of others. Some of the illustrations are good and others are poorly produced.

This book will have limited interest to most physicians, but will serve as a useful reference to those concerned with such defects. *Harris D. Riley, Jr., MD*

Communicable Infectious Diseases. Seventh Edition. By Franklin H. Top, Sr., MD, and Paul F. Wehrle, MD, 803 pp. C. V. Mosby Co., St. Louis, 1972.

This book originally edited by Top has been a major and popular text in the field of infectious diseases for more than a third of a century since its first edition in 1931. The new co-editor, Paul Wehrle, and the 25 new well-qualified contributors, have brought the scientific and epidemiologic knowledge of their subject matter up to date while maintaining the scholarly and historical viewpoints. It contains five additional chapters since the last edition but with an increase of only 75 pages making it clear that a large proportion of the book has been completely rewritten by the new contributors. This edition is dedicated to Alexander D. Langmuir, formerly Chief of the Epidemiology Branch of the Center for Disease Control.

This edition can be recommended for all concerned with infectious diseases as an authoritative presentation of the problem. *Harris D. Riley, Jr., MD* □

Miscellaneous Advertisements

BURROUGHS 1500 POSTING MACHINE with typewriter, completely programmed for itemization of medical bills. Can also do accounts payable. Also, Burroughs series 50 posting machine programmed for itemization of medical bills. Write or call Mr. Joe Crosthwait, MD, 7221 East Reno, Midwest City, Oklahoma or 405 737-4405.

NEWLY CONSTRUCTED, multi-specialty clinic in Lubbock, Texas has openings in areas of OB-GYN, Internal Medicine and Family Practice. New 120-bed hospital adjacent to clinic. Top salary leading to partnership. Interested applicants send curriculum vitae to University Medical-Surgical Clinic, 6602 Quaker Avenue, Lubbock, Texas 79414.

WILL BUY X-RAY FILMS, LEAD AND HOSPITAL equipment. Finders fee available. Sick room rentals. **BUY — SELL — TRADE.** C. E. Clancy, 634-0111.

OFFICE EQUIPMENT FOR SALE — 4200 National cash register posting machine appropriately coded for medical practice, used in multispecialty group practice. Would be suitable for backup unit or spare parts. Also available, Edison central dictating unit, consisting of 13 separate phone units, two central receivers, 1 LP TV tape unit and two unit dictators. Will sacrifice. Contact Jim Loy, Chickasha Clinic, 224-4853.

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INTERNAL MEDICINE REVIEW COURSE

1975

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DATE TITLE — SPEAKER

March 19, Gastroenterology I—Gastroenterology
Section

March 26, Congenital Heart Disease In The Adult—
Lofty L. Basta, MD

April 2, ASCVD and Cardiomyopathies—Stephen D.
Shappell, MD

April 9, Gastroenterology II—Gastroenterology Sec-
tion

April 16, Metabolic Disorders Presenting In The
Adult—Sylvia Bottomley, MD

April 23, Pituitary Adrenalin and Endocrine
Hypertension—David C. Kem, MD

April 30, Thyroids and Gonads—E. William Allen,
MD

Rondomycin (methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.

WARNINGS: Tetracycline usage during tooth development (last half of pregnancy) may cause permanent tooth discoloration (yellow-gray-brown), which is common during long-term use but has occurred after repeated short-term use. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in pregnancy.** (See above **WARNINGS** about use during tooth development.)

Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.

Usage in newborns, infants, and children. (See above **WARNINGS** about use in tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. In the rat, the growth rate observed in prematures given oral tetracycline 25 mg/lb/day was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.

To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum tetracycline levels. The anti-anabolic action of tetracyclines may increase BUN. Not a problem in normal renal function, in patients with significantly impaired renal function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and hypocalcemia.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should avoid exposure, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.

Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, give tetracycline with penicillin.

ADVERSE REACTIONS: **Gastrointestinal** (oral and parenteral forms): anorexia, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with white overgrowth) in the anogenital region.

Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Sensitivity is discussed above (See **WARNINGS**).

Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid reactions, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have appeared rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.

Over prolonged periods, tetracyclines have been reported to produce brown discoloration of thyroid glands; no abnormalities of thyroid function are known to occur.

USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 14 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.

Therapy should be continued for at least 24-48 hours after symptoms and signs have subsided.

Concomitant therapy: Antacids containing aluminum, calcium or magnesium may interfere with absorption and are contraindicated. Food and some dairy products also interfere with absorption. Pediatric oral dosage forms should be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be adjusted by reducing recommended individual doses or by extending time interval between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days. **SUPPLIED:** 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.



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One of the objectives of the auxiliary is to assist the medical association in its program to improve the quality of life through health education and service. The auxiliary's Community Health Committee strives to help its units make this objective a reality. We think of its role as an opportunity to help identify health problems in the community, to help identify health resources and to stimulate solutions to health problems through public education and volunteer services. Our Community Health programs and projects fall into two broad categories: prevention and care.

As a member of the Community Health Team for the Auxiliary to the Oklahoma State Medical Association, I attended the Southern Regional Workshop in New Orleans last October. In small informal sessions we had the opportunity to exchange ideas with other state Community Health Chairmen. We found the local units in each state, like individuals, unique and varied in their interests and accomplishments but all working to improve the quality of life through education and service. As a group we agreed our greatest problem is lack of communication and I appreciate the comments and suggestions presented to us in this column last month.

During our workshop we discussed some of the basic steps and principles which apply to virtually every program and project an auxiliary might undertake in Community Health. These steps include:

1. A survey of your community to find out what the needs are and what resources are available.
2. Establish priorities for meeting the most pressing Community Health needs.

3. Consult your medical society advisory committee.

4. Enlist the cooperation and help of other concerned groups and individuals in the community.

5. Set goals.

6. Evaluate your program.

7. Report your programs and projects to your state Community Health Chairman and medical society.

In one of our workshop sessions each Community Health Chairman gave a report on a successful project from her home state. I was proud to announce the National Award one of our local units (Tulsa County) had just received from The Woman's Conference of the National Safety Council for their work with a poison control project. Our National Community Health Chairman, Mrs. C. H. Gilliland, was in Chicago and present when this award was presented. She gave an impressive report for Oklahoma and urged other auxiliaries to compete for this award in the future.

The final workshop session was spent going through the package programs and kits. These program aids were developed by the Woman's Auxiliary to the American Medical Association to assist us in planning and implementing programs related to community health needs. Many of these program aids are being revised and you will find the latest factual information with guidelines to help you get your programs and projects off the ground.

Report time is just around the corner and I am looking forward to receiving a Community Health report from each local unit in Oklahoma. *Jewell Coates, Community Health Chairman to the Auxiliary of the Oklahoma State Medical Association.* □

The AMA will file a lawsuit to prevent implementation of the National Health Planning and Resources Development Act. The suit will seek to have the law declared unconstitutional as an unwarranted assumption of state authority by the federal government. The law, which replaces the present Comprehensive Health Planning Program and Regional Medical Programs, creates a system of Regional Health Systems Agencies with local and state agencies developing and implementing health plans under guidelines prepared by HEW.

President Ford's National Health Budget went to Congress. For fiscal year 1976 it calls for \$4.5 billion for non-Medicare-Medicaid programs, \$500 million less than Congress appropriated. The major cuts are in National Institutes of Health Research and in Alcoholism, Drug Abuse and Mental Health Programs. The NHI Budget was set at \$1.8 billion, compared with \$2 billion approved for fiscal year 1975. Alcoholism, Drug Abuse and Mental Health Programs are budgeted at \$702 million, compared with \$826 million approved by Congress, PSRO is budgeted to get \$50 million, a \$14 million increase. The Ford Administration pointed out that it might have to change the timetable for the formation of PsRO because of the shortage of funds.

Rigid Medicare and Medicaid hospital utilization review regulations published by the Secretary of Health, Education and Welfare on November 29th and effective February 1st have already caused at least one Oklahoma physician to curtail his small town medical practice. Louis C. Belter, MD, the only medical doctor in Fairview, has curtailed his practice in this northwestern Oklahoma community because the new regulations "put us in violation of the Oath of Hypocrates." Belter has taken other employment in Oklahoma City, but will try to

maintain some office and hospital practice for the present time.

The physician's protest not only relates to the federal regulations recently imposed but also to the Professional Standards Review Organization law now being imposed by Congress on the nation's physicians and hospitals.

OU Medical Alumni are reminded to circle Thursday, April 24th, on their calendars. This is the date that has been set aside during Oklahoma Medical Summit '75 for the alumni and spouses to get together for a fun-filled evening of "liberations, food, and entertainment". Entertainment will be furnished by Jayne Jayroe, former Miss Oklahoma and Miss America. Details will be sent to all alumni.

Medix, the award winning TV program produced by the Los Angeles County Medical Association, has become a nationally syndicated TV program. It will be broadcast on KWTU, Channel 9, in Oklahoma City. The 30-minute weekly show is designed to increase public awareness of health problems. It will be sponsored nationally, and in Oklahoma, by Burroughs Wellcome Company in conjunction with local medical societies. The content of each program is authenticated by a committee of the Los Angeles County Medical Association physicians. Currently 50 television stations, servicing about 50% of the nation, are planning to carry Medix.

The AMA is now involved in three separate lawsuits in Federal Court. It is suing the Health, Education, and Welfare to stop the enforcement of the new Utilization Review Regulations for hospitals, to stop the enactment of the Maximum Allowable Cost Drug Reimbursement Program, and to stay implementation of the new Health Planning bill. The AMA's new "aggressive posture" is being met with some enthusiasm by physicians throughout the United States. □

The

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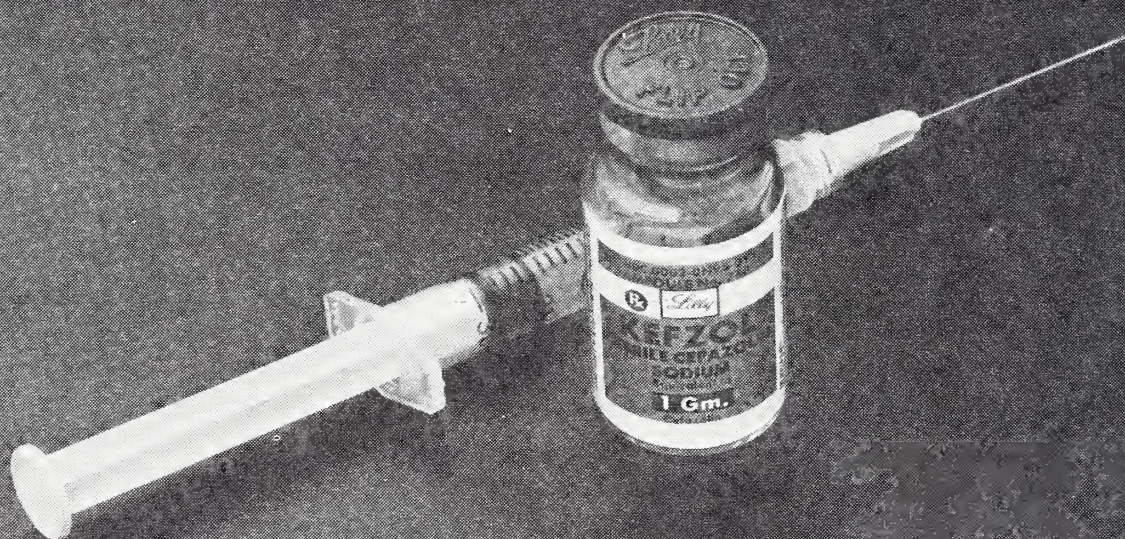
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The Hazards of Motorcycles

One crisp, fall afternoon a 19-year-old boy was carried into the emergency room of the hospital where I was serving my internship. His right leg was streaming blood from a laceration where he had hit the pavement after being thrown from his motorcycle. As I started to cut away his trousers, his wallet, comb, and a silver lighter fell out of the pocket onto the floor. The nurse brought a paper bag to collect his belongings, pausing for a moment to admire the engraved silver lighter.

I finished suturing the boy's wounds and admitted him to the hospital for observation because of a head injury. The next day I retrieved the bag and delivered it to his room. "You were lucky this time," I told him. "Your wounds will heal. But the chances of killing yourself the next time you get on that motorcycle are pretty good. If you are as smart as you look, you will get rid of the cycle."

The youth seemed unimpressed. "Tell you what, doc," he said, fishing the silver lighter out of the bag I had brought him, "If I get into another accident, you can have this lighter."

Two weeks later he was brought to the hospital, DOA. I've still got the lighter.

An increasing health problem in recent years is the rising number of injuries and deaths that have occurred as the result of accidents involving two-wheeled motor vehicles, chiefly motorcycles.

Since 1955 the number of motorcycle registrations has risen steadily, with a 450% jump from 1961-1971 when the total topped 3.3 million.¹ This compares with an overall motor vehicle increase of only 50%. On the average, there is now one motorcycle for every 62 persons in the United States. Many influences have fueled the motorcycle boom — the scarcity and cost of gasoline, a glut of small, inexpensive cycles from Japan, improvement in the image of the cyclist by such popular movies as *EASY RIDER*, and, of course, the activities of stuntman, Evel Knievel. More and more people have turned to two-wheeled vehicles for both recreation and economy. Police departments use cycles for traffic control, couriers use cycles to deliver parcels, and everyone from teenage boys to grandmothers rides cycles just for fun.

The rapid rise in the number of registered motorcycles in this country over the last decade has been accompanied by an increase in the number of fatal injuries to motorcyclists.

Deaths among drivers of motorcycles and their passengers have more than tripled between 1961 and 1971. While motorcycles may be economical to buy and operate, their true cost in terms of injury and death is excessive. The National Highway Traffic Safety Administration reports that during 1973, more than 3,000 motorcycle drivers and passengers lost their lives. This fatality rate was more than twice that for drivers and occupants of other types of motor vehicles. Calculated on the basis of the number of miles driven, the motorcycle is the most hazardous type of motor vehicle. The mortality for motorcycle riders is about 20 deaths per 100 million miles, five times greater than the rate for drivers and passengers of other types of vehicles.¹

Besides the greater risk of being involved in an accident, motorcyclists are also much more likely to be injured if a mishap does occur. The National Safety Council estimates that 90% of all motorcycle accidents involve personal injury or death, as opposed to nine per cent of all other motor vehicle accidents.² The design of a motorcycle offers little or no protection to its riders, and the handlebars, windscreen, and pedals can be potentially lethal. A study of motorcycle accidents in New York revealed that 39% of injured motorcycle operators suffered multiple injuries.³ One patient had six serious, primary injuries and 19 major, directly-related secondary problems. He was operated on 12 times before he died.

Injuries resulting from a motorcycle accident are usually much more severe than those sustained in an automobile accident. The motorcyclist, unprotected by the frame of his vehicle, is often catapulted against another vehicle, object, or pavement.¹ Furthermore, the risk to the companion "riding tandem" is quite substantial. Earlier studies indicated that 50% of accident victims sustained head injuries.⁴ This figure has dropped to around 24%, probably due to the use of helmets.⁵ Nevertheless, a helmet cannot offer full protection and may give the wearer a false sense of security. In fact, various studies suggest that even at present as many as two-thirds of the motorcycle fatalities result

editorial

from head injuries.¹ Head injuries still account for considerable morbidity among survivors, including impairment of intellectual function, paralysis, blindness, and convulsive disorders secondary to permanent brain damage.

Not only does the design of a motorcycle fail to offer protection, but it may also encourage drivers to take chances. Passing on the right, riding between two lanes of traffic, cutting in and out, and riding in the blind spot of automobile drivers have been cited as common practice among many cyclists.⁶ Furthermore, the cyclist may be unable to cope with instability on wet or icy pavement or gravel, longer braking distance, poor lighting at low speeds, and crowding by other vehicles.

Not only is the cyclist's visibility low, but many motorists will not give the cyclist the right of way even if they do see him. The New York study found that when a motorcycle collided with another vehicle at an intersection, the other vehicle was at fault 75% of the time.³ At other locations, however, the motorcyclist was twice as likely to be at fault. According to police records, the majority of accidents were due to a failure of the operator to obey the traffic laws or to have the motorcycle under control.

One of the particularly tragic aspects of the motorcycle story is that the majority of the accident victims are young people — children in their teens and young adults. Nationally, about two-thirds of the motorcycle fatalities occur in the 15-24-year age group.¹ This is cruel and needless waste. These young people have survived the first hazardous period of their lives and, in fact, are entering not only the safest

period, healthwise, during the life span, but also the period of maximum productivity to society. Many studies indicate that inexperience and lack of skill are of greater importance in motorcycle accidents than in automobile accidents.¹ Yet most beginner motorcyclists usually teach themselves with only a few "tips" from a friend or a dealer. Improved education for motorcycle riding should clearly be carried out in driver education courses, by the motorcycle industry and by automobile associations concerned with safety.

These grim statistics serve notice that motorcycle accidents have reached epidemic proportions, particularly among young people. Records for the first four months of 1974 show a 30% increase over the same period of 1973. Even if the victim escapes death, he is often physically and emotionally scarred for life. Regardless of what precautions are taken, motorcycle riding still carries a very significant risk of serious injury or death. *Harris D. Riley, Jr., MD, Children's Memorial Hospital, University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma* □

ACKNOWLEDGEMENT

Appreciation is expressed to R. D. Welsh for assistance in preparation.

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CERTIFICATION EXAMINATION

for

AMERICAN BOARD OF FAMILY PRACTICE

The American Board of Family Practice announces that it will give its next two-day written certification examination on November 1st-2nd, 1975. It will be held at five centers geographically distributed throughout the United States. Information regarding the examination may be obtained by writing:

Nicholas J. Pisacano, MD, Secretary
American Board of Family Practice, Inc.
University of Kentucky Medical Center
Annex No. 2, Room 229
Lexington, Kentucky 40506

Please Note: It is necessary for each physician desiring to take the examination to file a completed application with the Board office. Deadline for receipt of applications in this office is June 15th, 1975.

My tenure in office as President of this fine state medical association is rapidly drawing to a close and this will be my last communication to you on this page. The year has flown by, most likely due to the fact that you have kept me free of many idle moments. I should like herewith to thank you for the opportunity to serve you and for the fine cooperation and support I have received throughout the past many months. I am proud of our membership and honored that you allowed me to contribute in some small way to our organization.



By the end of this month I shall be replaced by a fine new president, Doctor Arnold Nelson of Midwest City. To those of you who have not had the pleasure of his acquaintance I highly commend him to you as a sincere, intelligent, dependable leader. I feel privileged to have known him better this past year and consider him a wonderful friend. I know that he will be accorded the same loyal support given me and I thank you for that.

During the past month our national organization did two things for which we should be grateful: It recognized the critical problem that exists in professional liability and it proceeded with the legal action it filed in Federal Court challenging the constitutionality of Utilization Review. The first has been long overdue, since such states as California, New York, Florida and others have been beleaguered for many years; the second points up the lack of foresight exercised by HEW in promulgating rules, reg-

ulations and controls that were either unwise, impractical or, at times, impossible.

I consider it unfortunate that many of the leaders in medicine rushed to support certain congressmen in proposing government purchase of Health Insurance for the unemployed. Not only could this possibly include more than ten million on a federal subsidy, but is just about as pure a form of socialized medicine as we have seen in this country. Note that at least two committees have already sought jurisdiction — the Senate Labor and Public Welfare Committee and the House Commerce Committee. It could include not only those who were jobless solely from adverse national economic trends, but also those who were jobless from inefficiency and lack of intent. The care of worthy persons should be on a local basis, managed by the state, determined by need; the physicians would have met this responsibility, as they did in years past. This would have been an opportunity once again for the profession to demonstrate its total public involvement, without any consideration of remuneration. It is to their credit that the administration is opposed to any plan for jobless coverage since "it is not feasible or affordable." The doctors can and will take care of the medical needs of the unemployed so long as such conditions exist. We have always done it — long before Medicaid and Medicare — and we can and will do it again! This is a message I sent the committee hearing a proposal and the message I sent to our national legislators prior to the onset of their deliberations.

Thank you, my Oklahoma colleagues, for all that you are doing for the people of this state. Your dedication to their welfare is a joy to see.

J. L. Richardson, M.D.

Penicillin Allergy

JAMES FREED, MD

Penicillin is the most common cause of allergy to drugs. This report reviews the pathogenesis of allergy to penicillin, the types of reactions and outlines principles of management for patients with such reactions.

Administration of penicillin is the most common cause of drug allergy. Manifestations of penicillin allergy run the gamut from allergic reactions to immunological mechanisms and occur in about five per cent of adults; the incidence in children is much lower. Despite the risk of allergic reactions, penicillins are the first choice for treating infections because of their bactericidal activity and relatively low toxicity.

The rate of penicillin allergy varies from one per cent to fifteen per cent; this can be explained by recognizing that (a) the nature of penicillin preparation, (b) the number of doses administered, (c) the mode of administration, and in particular, (d) the size of the dose, influence the frequency of allergic reactions.

Present evidence suggests that severe reactions are most likely to occur in patients with a history of atopy-asthma, hay fever, or atopic dermatitis. Partly because of the sometime in-

discriminate and injudicious use of penicillin, such allergic reactions have become increasingly frequent and severe. While anaphylactic reactions are rare in children, especially younger ones, the incidence among adults is increasing. It is estimated that there are 3,000 anaphylactic reactions annually, of which ten per cent are fatal. The marked increase in incidence and severity of allergic reactions to penicillin in adults may be a result of the repeated and frequent use of penicillin in childhood, when it presumably caused no reaction. Because penicillin is so widely used and acute reactions can often be prevented by observing proper precautions, it is important to know the characteristics of penicillin allergy.

A person who has reacted adversely to penicillin on one occasion may tolerate it subsequently and vice versa. The discovery that some persons who have never received penicillin can display hypersensitivity to small doses showed that the causes of this supposedly specific form of allergy are broader than the mere use of the drug. Many people are exposed to penicillins and may become slightly sensitized to the minute quantities found in milk and other dairy products.

The mechanism most commonly involved in producing untoward effects of penicillin is hypersensitization. The immune response to penicillins involves a large variety of antigenic determinants and several types of immunoglobulins, yielding a complex picture which is difficult to interpret.

Allergic reactions to penicillins occur in four groups. These reactions and their symptoms are as follows:

From the Department of Pediatrics, Children's Memorial Hospital, University of Oklahoma Health Sciences Center and Department of Institutions, Social and Rehabilitative Services, Oklahoma City, Oklahoma

- (a) Immediate Allergic Reactions — occurring 2 to 30 minutes after penicillin administration:
 - Urticaria
 - Hypotension or shock
 - Laryngeal edema
 - Wheezing
- (b) Accelerated Urticarial Reactions — occurring 1 to 72 hours after penicillin administration:
 - Urticaria or pruritis
 - Wheezing or laryngeal edema
 - Local inflammation
- (c) Late Allergic Reactions — occurring more than 72 hours after penicillin administration:
 - Morbilloform eruptions
 - Urticarial eruptions
 - Erythematous eruptions
 - Recurrent urticaria and arthralgia
 - Local inflammation
- (d) Some relatively unusual late reactions:
 - Drug fever
 - Immuno-hemolytic anemia
 - Acute renal insufficiency
 - Thrombocytopenia
 - Serum sickness

Skin reaction may appear in the absence of previous known exposure to the drug or promptly after the administration of the first dose, especially in individuals who have had prior allergic reactions to other substances. Eliminating penicillin usually results in rapid clearing of the allergic manifestations, but they may persist for two weeks or longer. In some cases, the reactions are mild and disappear while penicillin is still being given. Skin rashes of all forms have been observed when penicillin sensitization has occurred, most being urticarial. Fever may be the only evidence of a hypersensitivity reaction to the penicillins and usually disappears 24-36 hours after discontinuing therapy.

What is the immunological basis of hypersensitivity?

Antigen—Antibody—>Allergic Reaction

The first requirement for inducing an immune response is a complete antigen. Studies have shown that low molecular weight compounds (haptens) must react irreversibly with proteins to cause sensitization or elicit an allergic reaction.

Hapten—Protein—>Antigen

Chemically, the penicillins are intermediate

small peptides in the biosynthesis of proteins which are unique to fungi and, therefore, foreign to mammals. In the intact or partially degraded form, they readily couple with larger peptide or protein molecules by amide, carbon or disulfide linkages. In this they become antigenic with a specificity determined by the penicillin molecule acting as a multivalent hapten. All penicillins have the 6-amino penicillanic acid nucleus, and the haptenic determinants have a structure related to the nucleus. Hence, all forms of penicillin are, to some extent, cross-allergenic.

In human penicillin allergy of the humoral type, at least two different antigens are operative.

These antigens are as follows:

- (a) Major determinant, benzylpenicillin polylysine, and benzylpenicilloyllysine groups, and
- (b) Minor determinant, mixture of benzylpenicillin, benzylpenicilloate, and alpha-benzylpenicilloyl-amine.

Powerful, proteinaceous antigen with penicilloyl specificity may be present in commercially certified pure penicillin. This antigen, which can stimulate the production of immunizing and sensitizing antibodies, can evoke the characteristic anaphylactic responses in doses of 1 ug or less in sensitized subjects.

The above finding fits well with the fact that life-threatening anaphylactic responses are characteristically observed with the natural penicillins, G and V, since de-acylation and replacement of side chains by re-acylation removes the proteinaceous residue from the semi-synthetic penicillins. Since alimentary digestion can also remove this proteinaceous substance, the lower incidence of anaphylactic reactions with the use of oral penicillin is also explained.

The possibilities of eliciting penicilloyl-specific allergic reactions in penicillin therapy have not been fully explored. Commercial penicillins are regularly contaminated by small quantities of penicilloyl compounds. The extent of this contamination is an important factor in whether a penicilloyl-specific allergic reaction occurs during penicillin therapy.

Antipenicillin antibodies are detectable in virtually all patients who have received the drug and in many who have never knowingly been exposed to it.

Two types of antibodies are found: (a) skin-sensitizing antibodies, involved in anaphylaxis

and urticaria, which some authors feel are of the IgE family, and (b) hemagglutinating antibodies, IgE and IgM, which are merely indicators of the immunological response and not the cause of penicillin allergy.

Synthesis of antibodies to both types of determinants (major and minor) appears to be linked. Clinical and immunological studies suggest that immediate allergic reactions are mediated by skin-sensitizing antibodies, usually of minor-determinant specificities. Accelerated and late urticarial reactions are usually mediated by major-determinant specific, skin-sensitizing antibodies.

The hemagglutinating antibodies which can be demonstrated by the hemagglutination technique are widespread and can be found as often in non-allergic as in allergic subjects, although in the latter the titers may be higher. Their presence is a natural immunochemical reaction to penicillin in any form. In fact, they may protect against allergy by acting as "blocking antibodies" when penicillin is administered, competing for antigen with the skin-sensitizing, anti-penicilloyl antibodies. Their presence does not mean that the same individual will inevitably react adversely to penicillin; he has the capacity to react, but as often as not fails to do so. This is probably because the excess of penicillin or its degradation products in unconjugated form act as univalent inhibitors of the small amount of penicillin conjugated multivalently as hapten with protein or peptide in the injection material or tissue.

There are, therefore, two universal protective mechanisms against allergy: (a) blockage of antigen by circulating antibodies and (b) hapten inhibition. Allergy results when these protective mechanisms are deranged. How then does the physician decide what to do in cases of penicillin allergy?

History — A detailed case history of penicillin administration and allergic reactions should always be taken. Factors of historical significance include atopy, history of reactions to other drugs, frequency of penicillin exposure, route of penicillin administration, and type of penicillin preparation. If penicillin allergy is suspected in a patient, the indication for penicillin therapy should be re-evaluated. In many cases, penicillin is not absolutely required or may be replaced advantageously by another antibiotic. If penicillin must be used

and the history is of no benefit, then predictive tests are indicated.

The value of objective predictive tests is twofold:

- (a) to screen out the severe allergic reactor to penicillin and
- (b) to enable the physician to use these valuable drugs in patients who, although they have past histories of penicillin allergy, could now tolerate penicillin therapy without allergic reaction.

Two preparations are now being used experimentally in skin testing for penicillin sensitivity:

- (a) PPL (Penicilloyl-polylysine, BPO or BPL) and
- (b) MDM (minor determinate mixture) which contains a solution of penicillin and several of its degradation products.

These two tests detect skin-sensitizing antibodies (reagins) of benzylpenicilloyl specificity and minor haptenic determinant specificity. They were designed to detect mainly the immediate, accelerated, urticarial reactors to penicillin. The tests are based on the hypothesis that immediate and accelerated reactions to penicillin are mediated by reagins which are present prior to penicillin therapy and which are detectable by skin tests with both PPL and MDM. PPL is much safer for testing than penicillin. Furthermore, it gives a much higher incidence (35%-75%) of positive intracutaneous test reactions in patients who have histories of penicillin reactions but have negative skin tests to penicillin itself.

Negative skin tests for PPL and MDM virtually exclude the possibility of an immediate allergic reaction and markedly reduce the probability of an accelerated urticarial reaction to penicillin. A positive skin test for PPL or MDM indicates a very high probability of an immediate or accelerated allergic reaction to penicillin.

Negative skin tests do not exclude the possibility of a positive Coombs' test or granulocytopenic or exanthematous reactions

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to penicillin as these reactions are not mediated by reagins. Exanthematous reactions, however, occur more frequently among patients with positive skin tests.

One must use the MDM in skin testing because the MD-specific skin-test-positive patients appear to be those with the highest risk of an immediate allergic reaction to penicillin. This seems to be so because of two reasons:

- (a) minor determinant specific reagins may have unusually high binding affinities and
- (b) concentration of minor determinant specific blocking antibodies may be low.

Since PPL and MDM are not generally available, many clinicians use a scratch test with various dilutions of penicillin. This test can be started with a drop of penicillin G solution containing 1,000 units/ml followed in 20 minutes by a scratch test with a solution containing 10,000 units/ml. This can be followed by an intradermal test of 0.01 ml of a solution containing 1,000 units/ml. It is best to test with equivalent dilutions of the specific penicillin preparation to be used. Whenever skin tests are performed, epinephrine and a tourniquet should be at hand so that systemic reactions can be controlled without delay. If the skin tests are negative, therapeutic doses of penicillin can be administered with reasonable assurance that immediate, life-threatening reactions will not occur. Penicillin should not be used for either testing or therapy in patients with a history of immediate, allergic reactions because the test itself could be fatal.

There has been some interest in studies of the serum of penicillin-allergic individuals, mainly to detect the presence of specific hemagglutinating antibodies. In patients with a negative skin test, the hemagglutination technique is of no value in predicting immediate reactions or accelerated, urticarial reactions to penicillin. If the skin test is positive, the following can be deduced:

- (+) skin tests — Low hemagglutination — good chance of anaphylaxis
- (+) skin tests — High hemagglutination — little chance for anaphylaxis, but may have accelerated urticarial reaction.

Even with all this, it must be remembered that any given dose may inhibit as well as provoke a response; a single trial dose or a single negative skin test does not always guarantee safety.

Ampicillin is associated with drug rash more often than other penicillins. Yet, from the molecular structure underlying all of the penicillin preparations, and from the existence of cross-reactivity, it might be expected that each preparation would tend to produce rash with approximately equal frequency. Furthermore, most of the excess rash with ampicillin seems to occur after an interval of at least a week following exposure; during the first week, rash occurs about as often as with the other penicillins. Why is this so? First, early rash with both ampicillin and other penicillins is related to antigens present in all the preparations. With ampicillin, late rash in some patients may be due to sensitization to the same antigens, but the excess, compared with other penicillins, could be due to the presence of additional impurities.

The cephalosporin derivatives are often the alternative drugs of choice for patients who are hypersensitive to the penicillins and who need a parenteral or oral agent effective against bacterial infections for which a penicillin is indicated. However, the cephalosporins are themselves capable of inducing allergic reactions. The cephalosporins have a different nucleus from the penicillins and are usually tolerated, but there is some evidence that a cross-reaction immunochemical complex with penicillin must be operating. Some feel that it may represent common or very similar contaminants. The actual picture is still not clear. The use of a cephalosporin in patients allergic to penicillin is, therefore, not without risk, and the patient must be closely observed for evidence of an allergic reaction.

If a penicillin is urgently needed by a patient with a history of immediate reaction or if the skin tests are positive and the patient cannot tolerate any alternative drug, desensitization might be attempted. Such circumstances are, however, quite rare. Starting several hours before desensitization is begun, a parenteral corticosteroid or antihistamine is administered as an intravenous infusion which is continued during the initial stages of desensitization. The success of desensitization is not predictable, and it should be done only on hospitalized patients under constant supervision by experienced personnel with equipment for respiratory and circulatory assistance at the bedside.

Because of the risk of severe allergic reactions, penicillin should be used with caution

and never for mild, self-limiting infections. Except in very severe infections, the drug should be administered orally to avoid the greater risk of parenteral administration. A physician administering penicillin should always be prepared to deal with severe reactions. When there is reason to believe that the patient is sensitive

to penicillin, another antimicrobial agent effective against the organism causing the infection should be used if possible. In the rare instances in which no other drug is a reliable substitute, skin tests and desensitization to penicillin may be indicated. When a cephalosporin drug is used in place of penicillin, the physician should also be aware of its sensitizing potential. □

PHYSICIANS' PHOTO CONTEST

Physicians and spouses interested in photography are invited to enter the Oklahoma Medical Summit Photo Contest to be held during the April 23rd-26th meeting at the Lincoln Plaza Forum.

The rules are as follows:

Rule 1. All entrants must be members of at least one of the sponsoring organizations of Oklahoma Medical Summit (OSMA, OCCS, or OAFP) or the spouse of a member.

Rule 2. Entries may be either black and white or color prints with a minimum size of 5 x 7 inches up to a maximum of 16 x 20 inches. (Sorry, no slides or transparencies.)

Rule 3. Photos may be of any subject matter (portrait, scenic, general interest, scientific, etc.)

Rule 4. All entries must be in the Oklahoma State Medical Association office no later than Monday, April 21st, 1975 . . . or entries may be brought to the Lincoln Plaza Forum on Wednesday, April 23rd.

Rule 5. Each entry must be clearly marked so that its ownership may be easily ascertained. All photos will be returned to their owners after the Oklahoma Medical Summit meeting.

Rule 6. No special mountings or frames are required. However, it would be appreciated if the photos were at least matted on some form of stiff backing.

Rule 7. Entries are limited to two photos per person.

Prizes will be awarded.

MAIL OR SHIP ENTRIES TO: Oklahoma State Medical Association, Attention, Mr. Ed Kelsay, 601 N.W. Expressway, Oklahoma City, Oklahoma 73118.

Hill of Mercy: Chimborazo Military Hospital, 1861-1865

RONALD C. CURNUTT, MEd

Chimborazo Hospital, near Richmond, Virginia, was the largest military hospital of the Civil War. During the four years which it served the Confederate Army, 77,889 patients were admitted.

Chimborazo Hill rises above the James River near Richmond, Virginia, much like the original Chimborazo in the Andes Mountains of Ecuador.¹ At the top of the steep slope rests a forty acre plain on which the headquarters of the Richmond National Battlefield Park is now located. The tree-lined park commands a magnificent view of the surrounding countryside. Once the site of the largest military hospital in the United States, today, Chimborazo is used for recreation and by tourists in search of America's past.

After the Confederate Army's initial victory

at First Manassas in July, 1861, the Army, under General Joseph E. Johnston, settled in for the first winter encampment of the war. However, camp life proved to be much deadlier than the sting of battle. Seventy-five percent of all Confederate military deaths were attributed to disease. Southern medical records estimate approximately 3,600,000 cases of disease and wounds, with 200,000 fatalities.² In the spring of 1862, General Johnston's army, massed at Centreville, Virginia, had 9,000 sick and wounded.³ In April, General George B. McClellan's Union forces made the opening moves of the Peninsular Campaign which was designed to capture Richmond and end the war. General Johnston immediately needed to transfer his forces from Centreville to the defense of Richmond. This move necessitated finding quarters for his sick and wounded. Johnston presented the problem to Doctor Samuel P. Moore, the Surgeon-General of the Confederacy. A total of only 2,500 hospital beds were available in Richmond. Doctor Moore turned to Doctor James B. McCaw, the administrator of a small military hospital on Chimborazo Hill near Richmond.

Doctor McCaw was Surgeon-In-Charge of the



1. Doctor James Brown McCaw. (From a photograph)

hospital which had been established in October, 1861, in several unfinished buildings on Chimborazo Hill. McCaw was the fourth member of his family to practice medicine, beginning with his great-grandfather in the Revolutionary War. Born in Richmond on July 21, 1823, he received his medical education at the University of the City of New York. Before the war, he served as editor of the *Virginia Medical and Surgical Journal* and as Professor of Chemistry and Pharmacology at the Medical College of Virginia. During the war, in addition to serving at Chimborazo with great distinction, McCaw also edited the *Confederate States Medical and Surgical Journal*, the only medical journal published by the Confederacy.⁴

Chimborazo Hill, lying to the east of Richmond, is separated from the center of town by Bloody Run Gulch. In April of 1862, the arrival of 4,000 patients from Johnston's army at Centreville marked the beginning of Chimborazo as the major medical center of the Confederacy. Of the 154 military hospitals in the South, Chimborazo was the largest. During the war, 77,889 patients were admitted, and the hospital administered 8,400 beds at one time.⁵ Lincoln Hospital in Washington, DC, which served 46,000 patients, was the largest Union military

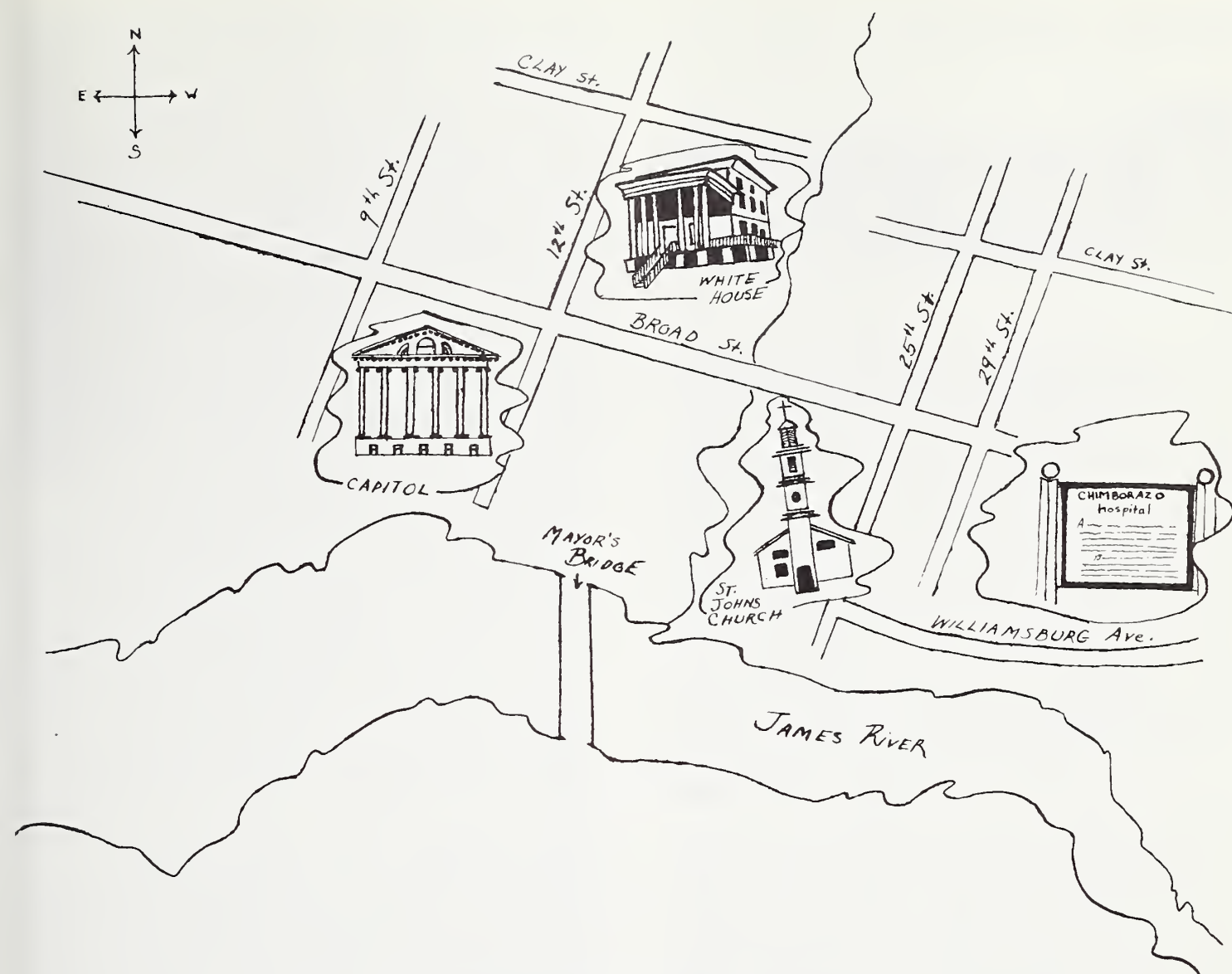


1. Chimborazo Hill looking toward the James River Valley and Richmond.

hospital.⁶ The Secretary of War designated Chimborazo as an independent army post with Doctor McCaw as Commandant and Medical Director. This exempted Chimborazo from the order of October 28, 1862, which placed general hospitals under the authority of local military commanders. McCaw named the institution Chimborazo Hospital.

Chimborazo Hill was well suited for the site of a hospital, since the heights offered excellent ventilation and natural drainage on three sides. There was an abundance of good water supplied by three natural springs and five deep wells. Chimborazo's proximity to Richmond was also an advantage. The only Confederate medical school in operation, the Medical College of Virginia, was located in Richmond. McCaw served on the faculty, and students assisted at Chimborazo. The office of the Surgeon-General was also located in the capital at Richmond. Chimborazo benefited from the watchful eye of Doctor Moore.

Doctor Moore introduced the hut, or one-story pavilion hospital.⁷ Chimborazo had 130 of these single story buildings. Each building was 100 feet long and 30 feet wide and housed from 40 to 60 patients. Ventilation was provided by the doors and windows. Beds were arranged in single rows along each of the ward sides, allowing from 800 to 1,000 cubic feet of air for each patient.⁸ Doctor Charles Tripler, Medical Director of the Army of the Potomac, commented on the buildings: "They admit of more perfect ventilation, can be kept in better police, are more convenient for the sick and wounded and their attendants, admit of a ready distribution of patients into proper classes, and are



2. Map of Richmond. (Original composition)

cheaper.”⁹ Chimborazo was divided into five separate hospitals or divisions, each with thirty buildings or wards. One of Chimborazo’s assistant surgeons recalled, “The hospital presented the appearance of a large town, imposing and attractive, with its alignment of buildings kept whitened with lime, streets and alleys clean.”¹⁰ Officers’ wards were separate from enlisted men. Some patients were housed in Sibley tents on the slopes of the hill.

The Richmond tobacco factories, closed by the war, contributed much to Chimborazo Hospital. Lumber from tobacco packing boxes was used to build furnishings, and factory boilers were utilized in Chimborazo’s soup houses. Even tobacco laborers were used to construct the hospital. Chimborazo had all the facilities of a small village, including a brewery with a capacity of 400 kegs of beer. Storage vaults for the beer were built into the eastern slope of the hill. The hospital had a bakery that supplied 10,000 loaves of bread a day, five soup houses, five ice houses, and a Russian bathhouse. Soap was

made with the grease from the soup houses.¹¹ There were five morgues in the hospital area, and Oakwood cemetery was used when needed. A guard house was maintained for unruly convalescents and attendants. The hospital was administered from the Richard Laughton house, the only two-story building on the grounds. St. John’s Church, where Patrick Henry made his famous “Give me liberty or give me death” speech was only a few blocks away.

Tree Hill Farm, owned by Franklin Stearns, pastured Chimborazo’s 200 cows and 500 goats. Doctor McCaw considered kid meat “most nutritious and palatable for sick and wounded men.”¹² A canal boat, “The Chimborazo,” sailed the James River obtaining supplies. Late in the war, Sheridan’s Raiders captured one of Chimborazo’s boats with a cargo loss of \$58,889.¹³

The Act of September 27, 1862 assigned the wounded and ill to hospitals by the states from which they served. This arrangement enabled officials to locate the patients more quickly and



3. Chimborazo Hospital as it looked during the war. (From a photograph, National Archives)

easily. They were also housed among people from the same geographical area with common manners and customs. This facilitated the distribution of materials sent by state governments, associations, and private groups. Chimborazo handled patients from Maryland, Virginia, Tennessee, Kentucky and Missouri. Mrs. Arthur Hopkins, wife of the Chief Justice of Alabama, helped establish an Alabama section at Chimborazo later. During the course of the war, she contributed \$200,000 to the relief of Confederate sick and wounded.¹⁴

Chimborazo, like most Confederate institutions, constantly struggled to keep its personnel up to strength. Each of the five divisions had a surgeon-in-charge, and there were fifty assistant surgeons assigned to the wards. When military doctors were not available, contract surgeons, who ranked below commissioned officers and received less pay, were used.¹⁵

Phoebe Pember, Chief Matron of Division II, was skeptical of the quality of many of the surgeons approved for work. She wrote in her diary, *A Southern Woman's Story*, "Coming to Richmond he [the applicant] passed the board of surgeons by a process known only to themselves, which often rejected good practitioners, and gave appointments to apothecary boys."¹⁶ Many of the young surgeons were lax in their duties and attendance. The problem of alcohol also caused embarrassment to some of the staff. One intoxicated surgeon set the wrong leg of a patient. However, the majority of Chimborazo's doctors were dedicated and hard-working, as the remarkable record of the institution indicates.

The second largest group of hospital personnel at Chimborazo was the matrons. There were forty-five matrons on the staff with Mrs. Minge as Head Matron.¹⁷ The Act of September 1862 authorized two head matrons, and two matrons for each ward. Preference, in all cases, was to be

given females "where their services may best be used."¹⁸ Mrs. Pember commented on the opening of a position for women: "Now that the field was open, a few, very few ladies, and a great many inefficient and uneducated women, hardly above the laboring classes, applied for and filled the offices."¹⁹ Feminine entrance into the male domain did not go unnoticed. The new matrons were called the "petticoat government." On Mrs. Pember's first day, she overheard a member of the staff comment, "one of them has come."²⁰ Mrs. Pember described her duties: "I have entire charge of my department, seeing that everything is cleanly, orderly, and all prescriptions of physicians given in proper time, food properly prepared and so on."²¹

The Act of August 21, 1861 authorized southern hospitals to employ nurses, cooks, and other needed personnel. These staff members were under military control, and their pay was less than that allowed enlisted men. Stewards were responsible for the cleanliness of the wards, kitchens, and patients, and were also custodians of the hospital store. Convalescent patients were expected to help when needed. Surgeon-General Moore wrote his medical directors: "Soldiers who have lost their left hand or arm, and otherwise healthy, but who are incompetent to perform clinical duty, can in the use of a pistol, act as efficient guards for hospitals and purveying depots."²² Convalescents were used for guarding, gardening, and even nursing. Mrs. Pember felt, "This arrangement bore very hard upon all interested, and harder upon the sick, as it entailed constant supervision and endless teaching."²³ John Herbert Claiborn directed Chimborazo's Commissary. The Quartermaster was Colonel A. S. Buford. There were also two apothecaries, one clerk, and a chaplain.²⁴

Chimborazo, an official army post, had a detail of thirty soldiers commanded by Captain Thomas E. Ferrell, whose duty was to maintain order. By early 1863, Chimborazo's garrison in-

Ronald C. Curnutt has a BA and an M Ed summa cum laude from Central State University. He was listed in Outstanding Young Men of America in 1973. Mr. Curnutt is now teaching history at Arizona Western College and Parker High School, Parker, Arizona. This paper was originally written during a course in the History of Biomedical Sciences at the University of Oklahoma Health Sciences Center.

creased to 164 troopers on active duty. By an order of July 8, 1863, four days after the defeat at Gettysburg, all fit men were ordered to the front. Replacements for the hospital garrison were made up of convalescing soldiers. The South's "peculiar institution" also played a role at Chimborazo. Doctor McCaw believed that it would have been impossible to continue the hospital without aid of the 256 slaves assigned there. Paper work was another burden handled by the administration of Chimborazo Hospital. An order of Doctor McCaw's, dated January 16, 1863, directed that all surgeons-in-charge hand in on the first of each month the following:

1. An accurate list of all the servants stating the names of owners and rate of hire.
2. A list of medical officers noting all changes during the past month and giving the ranks and date of appointment of those who came in during the month.
3. A monthly report of the sick and wounded accompanied by a list of the patients vaccinated and a report of the surgical cases.
4. All other reports required by the regulations.

All requisitions as far as possible must be made according to regulations stating length of time and number of patients meant for. They must also state the quantity of each article on hand. The patients, nurses, and attendants must be carefully counted on the 10th, 20th and 31st of each month and the morning report corrected thereby.²⁵

McCaw's own paperwork was not immune to criticism. Surgeon-General Moore wrote: "All accounts current sent from your hospital are full of defects, and made out in a manner which does not meet the approbation of this office." On one occasion, authorities complained that his morning reports were carelessly and inaccurately kept.²⁶

Chimborazo, like all institutions, lived by its schedule. Breakfast was served at 7:00 am during the summer and at 8:00 am during the winter. After breakfast, surgeon's rounds were made. The surgeon-in-chief received reports from the division surgeons once a day. The division surgeons made ward rounds once a day, while the assistant surgeons made rounds twice a day. During the rounds, the assistant surgeons filled out the diet lists at the foot of each patient's bed. These printed forms included the patient's name, bed number, type of diet, and quantity of whiskey allowed. Dinner

was served at 2:00 pm and supper at 6:00 pm. All transportation from the hospital was discontinued at 8:00 pm.

Near the end of the war, the staff acquired another duty. Three of the oldest surgeons were chosen to serve on a board which granted patient furloughs. This was a thankless task which required strict adherence to the rules to prevent abuses.

The Act of September 27, 1862 also set up financing for southern hospitals. Rations were fixed at a commutation of \$1.00 per man. This money was placed in a hospital fund to purchase supplemental rations which were unavailable in government stores. The amount was frequently raised as inflation diluted southern currency.²⁷ The finances at Chimborazo were always in good order. McCaw reported, "We never overdrew fifty dollars from the Confederate States Government, but relied solely upon the money received from commutation of our rations." At the close of the war the Confederate Government owed Chimborazo a sum of nearly \$300,000.²⁸

All commodities, including medical supplies, became scarce in the South as the blockade and war continued. The Union Government declared all medicines and surgical instruments contraband. Those supplies which were slipped through the blockade were expensive and hard to find. No source was overlooked in the search for medical necessities. Medical supplies were captured from the Union Army, supplied by donations of private individuals, and illegally traded for cotton with northern traders. The South also maintained a number of pharmaceutical laboratories during the war. Surgeon-General Moore, who did extensive work on native remedies, requested that Doctor McCaw test and investigate these at Chimborazo.²⁹

Almost 78,000 patients were admitted to Chimborazo, but only 17,000 of these were battle casualties. Approximately 7,000 of those treated for wounds died. Chimborazo's overall mortality rate was a little over nine percent.³⁰ Surgeon S. E. Habersham reported that the most serious diseases treated at Chimborazo included adynamic fevers, sloughing phagedema, phosedenia, gangrenosa, pyemia, erysipelas and neuralgic afflictions following continued fever.³¹ Chimborazo medical records showed the following statistics on disease:

Pneumonia and pleurisy, 1,568 cases, 583 deaths.



2. Chimborazo Park, the hospital site today.

Debility and anemia, 5,780 cases, 117 deaths.

Scurvy, 119 cases, 8 deaths.

Rheumatism, 1,984 cases, 90 deaths.

Typhoid, 1,388 cases, 661 deaths.

Erysipelas, 236 cases, 22 deaths.

Tuberculosis, Catarrh, Bronchitis, 189 cases, 52 deaths.

Diarrhea and dysentery 10,503 cases, no deaths.³²

Many of the surgical operations performed at Chimborazo were secondary amputations following initial surgery done at the battlefield aid stations. Mrs. Pember commented:

Poor food and great exposure had thinned the blood and broken down the system so entirely that secondary amputations performed in the hospital almost invariably resulted in death, after the second year of the war . . . The only cases under my observation that survived were two Irishmen, and it was really so difficult to kill an Irishman that there was little cause for boasting on the part of the officiating surgeons.³³

Military hospital life during the Civil War was not very different from that of today. Food was especially significant to the patients. A petition complaining about the quality of the hospital diet, signed by 360 patients, was read on the floor of the Confederate Congress, in September of 1862. The prescribed meals in Confederate hospitals were full, half, or low diets. A full diet consisted of beef, bread, and vegetables; a half diet of soup, toast, and other light foods; a low diet was rice and milk. The attending surgeon determined the diet plan for each pa-

tient. It was not always possible to provide the type of food requested by the men. Mrs. Pember noted, "The habit so common among physicians when dealing with the uneducated people of insisting upon particular kinds of diet, irrespective of the patient's tastes, was a peculiar grievance that no complaint during four years ever remedied."³⁴

Shortages of food and supplies became major problems in the South as the war continued. Many humanitarian civilian groups contributed supplies to supplement the hospital rations. The women of Richmond made the Christmas of 1863 a feast day in Phoebe Pember's division. She stated:

We made twenty-four gallons of eggnog inviting all in the whole division to come and drink and gave to each a good sized cake. At two o'clock having roasted a dozen turkeys and seven gallons of oysters we shared them out and hoped that each man got his share.³⁵

A most highly prized item in the matron's store room was the supply of spiritous liquors. Each division was allotted one barrel a month for medicinal purposes. The ward surgeons would prescribe each patient's daily ration on his bed card. The matron was in charge of holding and dispensing the spirits. This duty caused many of the matrons great anxiety since everyone wanted a share of the scarce liquor supply. The doctors and hospital stewards did little to help, and sometimes hindered, the matrons with this worrisome chore.

The soldiers of the Confederacy found hospital life filled with monotony. Hospital desertion rates were high. The Department of Virginia reported 5,895 desertions between September of 1862 and August of 1864.³⁶ Discipline was always a problem, with theft, drunkenness, and gambling especially prevalent. The boredom was relieved by revival meetings, books from the library, and handicrafts. The men made toys and carved pipes. One patient in Division II was able to get as much as \$150 for his carved pipes made from ivy roots. Playing cards were always in great demand and short supply. The hospital saw many fads come and go. At one time, every patient desired a pair of crimson canvas shoes dyed with red juices. A button mania swept the wards with each patient trying to outdo the other. There was even a hat band "fever." The patients put gilt and tinsel bands around their hats and wore them in bed.

Mail and visitations were sources of great

comfort to the patients at Chimborazo. Mrs. Pember wrote that "Homesickness which wrings the heart and impoverished the blood killed many a brave soldier."³⁷ She wrote letters for the patients, but required them in return to perform some task of personal hygiene. Mail call was such an important event in hospital life, that the patients sent Doctor McCaw a petition asking for removal of the Chimborazo postmaster because he mispronounced the names on more than half the letters, took too long to make mail call, and made remarks about the writing on the letters. Visitations were hard to control since few rules seemed to regulate them. A Mrs. Daniels had a baby while visiting her husband. Another large family just moved in for six days and refused to leave. Such unwelcome guests were called "hospital rats."

Chimborazo passed its peak patient load by 1864. The morning reports for January, 1864 listed only 578 sick and wounded present. Doctor McCaw was ordered to transfer one of the divisions and let all nonessential personnel go. As the war's end neared, Chimborazo convalescents were expected to do their share of military duty. On Sunday, April 2, 1865, General Dick Ewell sent word to Captain Wood of the hospital's military garrison that Chimborazo's personnel were needed for the defense of Richmond. This last military service mobilized 1,200 staff members and convalescents.³⁸ The day after Richmond was evacuated by the Confederates, the Union Army, led by General Godfrey Wetzel, arrived at the hospital. Doctor McCaw was there to meet the new masters of Chimborazo Hill. Wetzel offered to place McCaw in the service of the United States so that he would have official authority to continue his duties. McCaw refused, however, stating that General Lee had not yet surrendered and that such action would be inappropriate.³⁹

The Federal Army took over the administration of Chimborazo, but the matrons were allowed to continue caring for Confederate patients. Rations remained scarce until the James River was cleared of obstructions. After making her last rounds of Division II, Mrs. Pember noted cynically:

Then I walked through my wards and found them comparatively empty. Every man who could crawl had tried to escape a northern prison. Beds in which paralyzed, rheumatic, and helpless patients had laid for months were empty. The miracles of the New Testament had been re-enacted.

The lame, the halt, and the blind had been cured.⁴⁰

A remarkable feat was accomplished at Chimborazo Hospital during the war despite the enormity of the task, the limitations of medical knowledge, the scarcity of supplies, and the restrictions on personnel. Chimborazo's place in history as America's largest military medical center was well-earned. □

ACKNOWLEDGEMENTS

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FOOTNOTES

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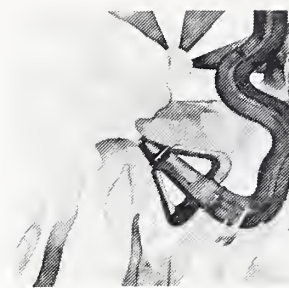
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Though measles immunization levels are quite satisfactory in many areas of the state, some communities still have levels sufficiently low to support local outbreaks. Sporadic cases can occur in any part of Oklahoma.

Measles should therefore be considered in all cases of rash illness. Unsatisfactory immunization can result in the appearance of atypical cases so that serological documentation of diagnosis is important.

The further attenuated vaccines have efficacy rates of approximately 95%. Immunization rates in school-age children are high enough in most areas of Oklahoma so that most cases are



News From
The Oklahoma State
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occurring in persons immunized with earlier vaccines (Edmonston B Strain), and in a small percentage (less than five percent) of children immunized with the further attenuated vaccines.

Eradication of measles in Oklahoma is possible during 1975. The number of outbreaks occurring and the numbers of cases involved make "outbreak containment" an attainable goal. No doubt measles cases will be imported from other states from time to time, however outbreaks can be prevented if diagnosis is accurate and reporting is prompt. Suspect measles cases should be reported to your local health department by telephone (collect). If your county has no health department, call the number at the bottom of this page. □

COMMUNICABLE DISEASES IN OKLAHOMA FOR FEBRUARY, 1975

DISEASE	February 1975	February 1974	January 1975	Total To Date	
				1975	1974
Amebiasis	2	—	1	3	2
Brucellosis	—	—	1	1	—
Chickenpox	185	91	125	389	135
Encephalitis, Infectious	—	3	2	2	6
Gonorrhea (Use Form ODH-228)	921	734	998	1919	1612
Hepatitis, A, B, Unspecified	68	128	100	173	208
Leptospirosis	—	—	—	—	—
Malaria	—	1	—	1	1
Meningococcal Infections	2	1	2	5	5
Meningitis, Aseptic	1	7	5	7	8
Mumps	15	51	17	33	74
Rabies in Animals	12	8	12	26	16
Rheumatic Fever	—	—	1	1	2
Rocky Mountain Spotted Fever	—	—	1	1	—
Rubella	4	3	42	54	13
Rubella, Congenital Syndrome	1	—	—	1	1
Rubeola	9	3	1	10	6
Salmonellosis	11	23	22	37	36
Shigellosis	17	13	103	122	25
Syphilis, Infectious (Use Form ODH-228)	9	10	13	22	25
Tetanus	—	—	—	—	—
Tuberculosis, New Active	28	20	17	48	41
Tularemia	—	1	—	—	1
Typhoid Fever	—	—	—	—	1
Whooping Cough	1	3	—	1	4

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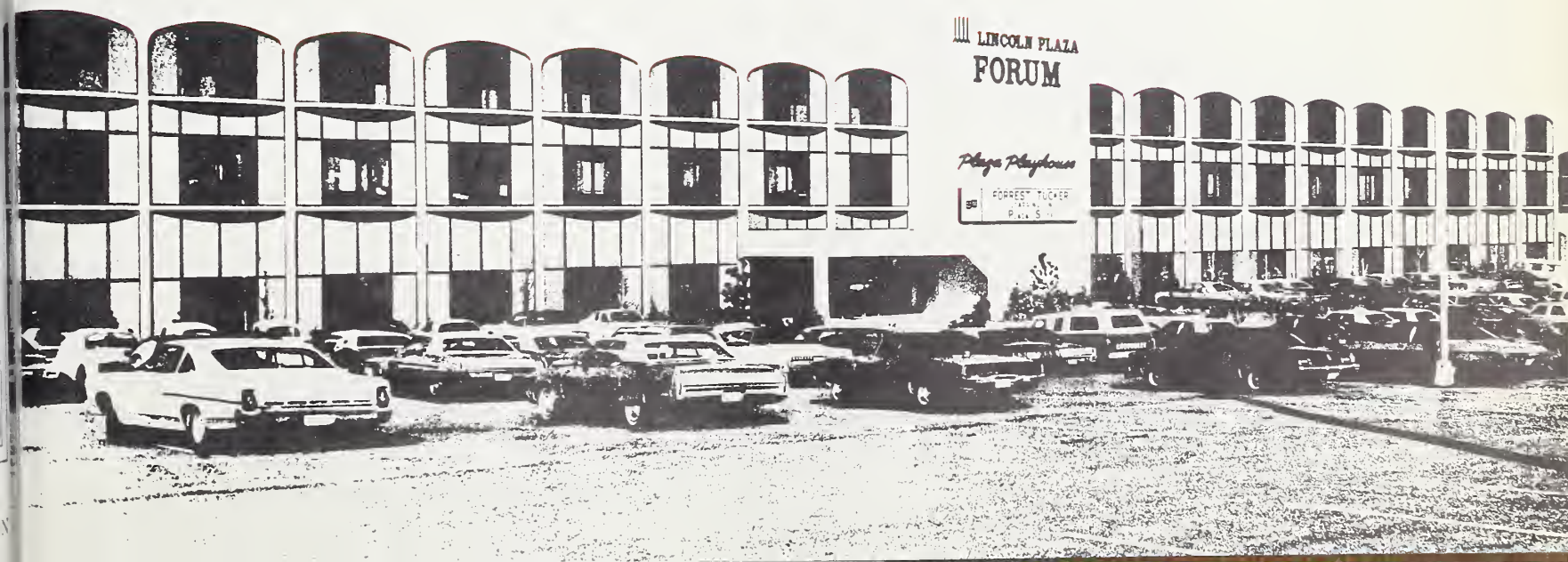
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Oklahoma Medical Summit '75



Oklahoma Medical Summit '75

(OAFP — OCCS — OSMA)

Oklahoma Medical Summit '75 is the combined annual meeting of the Oklahoma Academy of Family Physicians, Oklahoma City Clinical Society and the Oklahoma State Medical Association. It is scheduled for April 23rd-26th in the Lincoln Plaza Hotel's Forum.

Oklahoma Medical Summit is the state's largest medical continuing education meeting. Over 70 hours of continuing education will be offered in addition to numerous courses of interest to allied health personnel. The American Academy of Family Physicians is allowing 20 hours of prescribed credit for the meeting.

Oklahoma Medical Summit '75 will feature numerous social functions beginning on Wednesday evening, April 23rd, with the Early Bird

Party in the Lincoln Plaza Playhouse. Thursday evening, early, there will be a double-header: a Keg and Oyster Party and a Wine and Cheese Tasting Party. The social highlight of the year will be the President's Dinner-Dance on Friday evening, April 25th.

Oklahoma Medical Summit '75 planning has taken literally thousands of man-hours on the part of its various planning committees. Their purpose was to make this combination of the 69th Annual OSMA Meeting, 45th Annual Clinical Society Meeting, and 27th Annual Scientific Assembly of the Academy of Family Physicians one of the finest programs available. □

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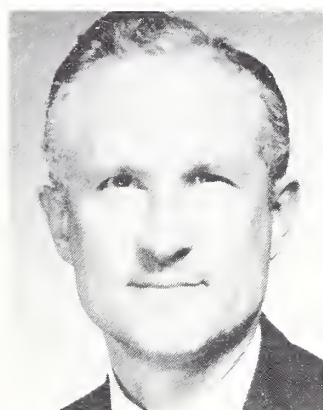
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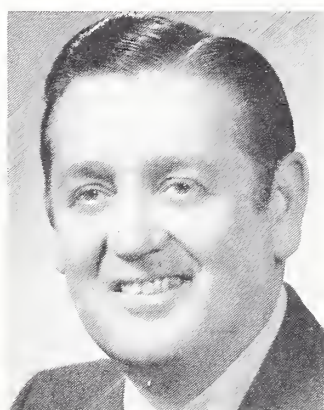
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DIGEST OF EVENTS

REGISTRATION

The registration area for Oklahoma Medical Summit '75 will be located in the lobby of the Lincoln Plaza Forum Building, 4345 Lincoln Boulevard, Oklahoma City. It will be open from 7:30 am until 5:00 pm Thursday through Saturday, April 24th-26th.

Admission to all scientific sections, exhibits and business meetings is by badge only, available in the registration area.

HEADQUARTERS

The Lincoln Plaza Hotel is the headquarters for Oklahoma Medical Summit '75. It is located at 4345 Lincoln Boulevard. All scientific meetings will be held in the Lincoln Plaza Forum Building, to the immediate south of the hotel building.

EXHIBITS

Nearly 100 exhibits will be located in the exhibit hall of the Lincoln Plaza Forum Building. The exhibit hall will be open from 8:00 am until 5:00 pm each day during the meeting.

MESSAGE CENTER

A message center will be maintained in the registration area throughout Oklahoma Medical Summit '75. The center will be available to receive messages and forward them to physicians attending the meeting.

PUBLIC SPEAKING SEMINAR

A Public Speakers Training Program will be conducted on Thursday and Friday, April 24th-25th, by the Smith, Kline and French Speakers Training Team. Attendance at the seminar is limited to 40 persons and advanced registration is necessary. Participants in the program will learn the principles of effective speech composition and delivery, manuscript speaking, extemporaneous speaking, and the use of visual aids. The seminar requires two full-days, from 8:30 am until 5:00 pm and follows a workshop format.

PHOTOGRAPHY SEMINAR

Amateur photography is rapidly becoming one of the most popular hobbies among physicians. A photography seminar for amateurs has been arranged for Saturday afternoon, April 26th. Presentations will be given by Raymond Riggs, an international salon exhibitor in amateur photography, and David Fitzgerald, a commercial photographer from Oklahoma City. The seminar will cover such subjects as camera selection, lens selection, film, handling techniques, composition, lighting and a few "tricks of the trade."

Following their formal presentations, the two photographers will be available for a question and answer session.

OSMA BOARD OF TRUSTEES

The OSMA Board of Trustees will conduct its annual business meeting Wednesday morning, April 23rd, starting at 9:00 am in the Lincoln Plaza Rotunda Room.

OAFP BOARD OF DIRECTORS

The Board of Directors of the Oklahoma Academy of Family Physicians will conduct a business meeting on Wednesday afternoon, April 23rd, starting at 1:00 pm in the Lincoln Plaza Forum Rotunda Room.

OSMA HOUSE OF DELEGATES

The OSMA House of Delegates will conduct two business sessions during Oklahoma Medical Summit '75. The opening session will be held Wednesday afternoon, April 23rd in the Lincoln Plaza Hotel's Lincoln Room. The meeting will start at 2:30 pm.

Reference Committees will meet starting at 8:00 am the following morning, Thursday, April 24th. Reference Committee meetings are open to all members of the association and will be held in the Lincoln Plaza Forum Building.

The closing session of the House of Delegates is scheduled for 9:00 am Friday morning, April

25th, in the Lincoln Plaza Hotel's Lincoln Room.

All items of business introduced during the opening session on Wednesday will be referred to one of the three Reference Committees for hearing on Thursday morning. Open hearings are held on all reports and resolutions to be considered by the House of Delegates.

Following the open Reference Committee hearings, the Reference Committees will prepare reports containing recommendations for presentation to the House of Delegates at its closing session on Friday morning. The election of officers will also be held during the closing session.

SCIENTIFIC PROGRAM

Over 70 hours of continuing medical education will be available during Oklahoma Medical Summit. The American Academy of Family Physicians has stated that it will allow its members a maximum of 20 prescribed hours.

Each of the three days will feature a number of different scientific sections available for physician-attendants.

WET CLINICS

There will be four wet clinics offered twice each during Oklahoma Medical Summit. These will be scattered throughout the first two days, Thursday and Friday, and will be on dermatology, ENT, emergency medicine and cosmetic surgery.

SUPERSTAR SPEAKERS

Four nationally prominent speakers and the Governor of Oklahoma will appear during Oklahoma Medical Summit '75. The superstar speakers include Joe T. Nelson, MD, American Medical Association Trustee; Herbert Holden, MD, President of the American Academy of Family Physicians; Phillip Thorek, MD, one of the nation's most sought after physician speakers; and, Henry Simmons, MD, Director of HEW's Office of Professional Standards Review.

In addition the new provost of the Oklahoma Health Sciences Center, William Thurman, MD, will appear.

Governor David L. Boren will be a featured speaker on Saturday, April 26th. □



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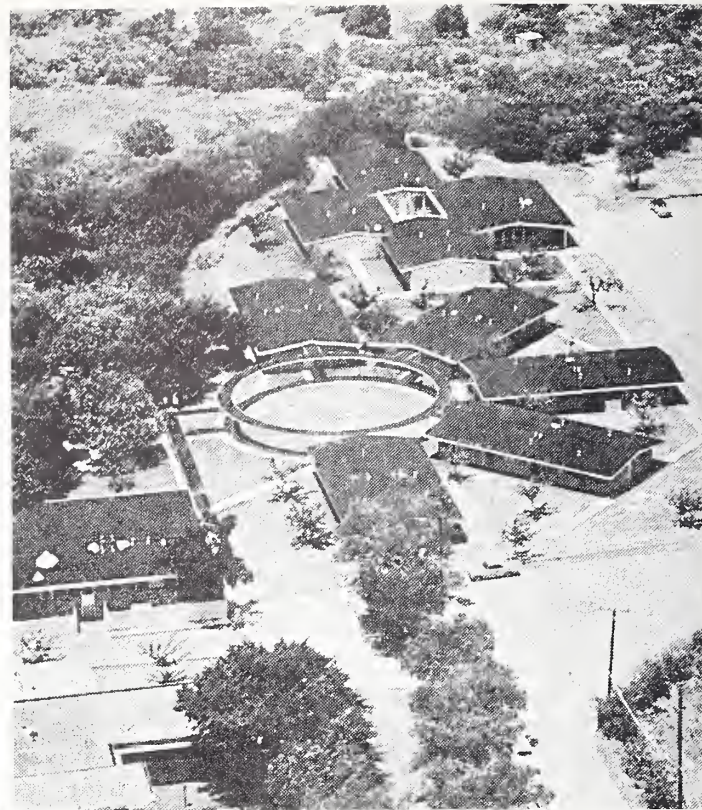
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PSYCHIATRY

Jackson H. Speegle, MD
John T. Holbrook, MD

Fred H. Jordan, MD
Joseph H. Lindsay, MD

PSYCHOLOGY

George R. Mount, PhD
Donald L. Whaley, PhD

Tom I. Payton, MS
Patrick R. Barnes, MS

EDUCATION DIRECTOR

William E. Nix, PhD

DIRECTOR OF NURSES

Nita Ivey, RN

O.T. AND R.T. ACTING DIRECTOR

Jeanette Boothe

COURTESY STAFF

1353 North Westmoreland Avenue, DALLAS, TEXAS 75211

214 331-8331

Technical Exhibitors

The Technical Exhibits of the Oklahoma Medical Summit may be seen in the Exhibit Area of the Lincoln Plaza Forum.

Abbott Laboratories
Academy Computing Corporation
Audio Equipment Company
Armour Pharmaceutical Company
Association of American Physicians and Surgeons
Ayerst Laboratories
Don Bernard's Indian Jewelry
Beverly Hills Hospital Inc.
R. K. Black, Inc.
Blue Cross-Blue Shield Plans of Oklahoma
Bristol Laboratories
Boehringer Ingelheim Ltd.
Burroughs Wellcome Company
Ciba Pharmaceutical Company
Cooper Laboratories, Inc.
Coyne Campbell Hospital
Credit Service
Danal Laboratories
Dow Pharmaceuticals
Eaton Laboratories
The Emko Company
Fisons Corporation
Fuller Laboratories
Geigy Pharmaceuticals
Health Care Management
Hoechst Corporation
Hospital Products, Inc.
International Medical Electronics, Ltd.
Ives Laboratories, Inc.
Lederle Laboratories

Eli Lilly and Company
Mallinckrodt, Inc.
Marion Laboratories, Inc.
Mead Johnson Laboratories
Medco Products Company
Medical Plastics Laboratory, Inc.
Merrell-National Laboratories
Metro Med Inc.
Meyer Laboratories, Inc.
Mission Pharmacal Company
Ortho Pharmaceutical Corporation
Parke, Davis and Company
Pfizer Laboratories
Professional Com-Data Corporation
Riker Laboratories, Inc.
A. H. Robins Company
Roche Laboratories
Roerig
Wm. H. Rorer, Inc.
Ross Laboratories
Sandoz Pharmaceuticals
Searle Laboratories
Smith Kline and French Laboratories
E. R. Squibb and Sons, Inc.
Stuart Pharmaceuticals
Tri-State Pharmaceuticals Company
USV Pharmaceutical Corporation
Upjohn Company
Wallace Laboratories
Wang Laboratories
Webcon Pharmaceuticals
Wyeth Laboratories

TELEPHONE MESSAGE

While physicians are attending the Oklahoma Medical Summit in Oklahoma City, emergency calls may be referred to:

525-8244

A courtesy message center will be maintained during Oklahoma Medical Summit in the Lincoln Plaza Forum Exhibit area.

DOCTOR, WHAT WILL YOU EARN?

It depends, of course, on your age and annual earnings, but the amount can quite reasonably exceed \$400,000.

The total value of all your possessions — property, savings, cars and personal belongings — is only a fraction of what you will probably earn during years of practice. And yet some of you have insured these things and left your earning power unprotected.

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PROGRAM

All events will be held in the Lincoln Plaza Forum unless otherwise noted.

Wednesday Morning, April 23rd

- 9:00 am** **OSMA BOARD OF TRUSTEES.** The annual business meeting of the medical association's Board of Trustees will be held in the Lincoln Plaza's Rotunda Room.
- 12:00 noon** **OSMA TRUSTEES LUNCHEON.**
- 12:00 noon** **OAFP DIRECTORS LUNCHEON.**

Wednesday Afternoon, April 23rd

- 1:00 pm** **OAFP BOARD OF DIRECTORS.** The annual meeting of the Oklahoma Academy of Family Physicians Board of Directors will be held in the Lincoln Plaza's Rotunda Room.
- 2:30 pm** **OSMA HOUSE OF DELEGATES.** The opening session of the OSMA's House of Delegates will be held in the Lincoln Plaza's Congress Room.
- 6:00 pm** **EARLY BIRD PARTY.** The first social event during Oklahoma Medical Summit '75 will be the Early Bird Party. It will start with a cocktail reception at 6:00 pm in the Lincoln Plaza Hotel's Congress Room. At 7:00 pm the party will move to the Lincoln Plaza Playhouse for dinner and a play. The play, starring Joseph Cotton, will be "The Reluctant Debutante." Tickets are \$12.50 per person.

Thursday Morning, April 24th

- 7:30 am** **GENERAL REGISTRATION.** General Registration for Oklahoma Medical Summit '75 will be in the lobby area of the Lincoln Plaza Forum Building.
- 8:00 am** **OSMA REFERENCE COMMITTEES.** The three Reference Committees of the OSMA House of Delegates will meet in assigned rooms in the Lincoln Plaza Forum Building. All members of the association are invited to attend.

- 8:30 am OBSTETRICAL EMERGENCIES.** The Oklahoma City Obstetrical and Gynecological Society has invited Lee B. Stevenson, MD, Grace Hospital, Detroit, Michigan, to be its guest speaker. He will be joined by Oklahoma City's Warren Crosby, MD.
- 8:30 am ANSWERS ABOUT MEDICARE.** Consultants from the Aetna-Medicare Claims Administration will be available for all three days of Oklahoma Medical Summit '75 to answer your questions about Medicare. These will not be formal presentations, but informal consultations with members of individual physician offices.
- 9:00 am DEFICIENCIES OF IMMUNITY.** This half-day session is being planned by the Oklahoma Society of Internal Medicine. Out-of-state guest speaker will be Alexander Lawton, MD, Associate Professor of the Department of Pediatrics, University of Alabama Medical Center, Birmingham. Topics will include "Humoral Immune Deficiencies: A Spectrum of Defects in B-Lymphocyte Differentiation," "Chronic Mucocutaneous Carditis" and "Cellular Immune Deficiency and Granulocyte Deficiencies."
- 12:00 noon SUPERSTAR LUNCHEON.** Guest speaker for the Thursday Luncheon will be Herbert Holden, MD, President of the American Academy of Family Physicians. Tickets are \$5 per person.

Thursday Afternoon, April 24th

- 2:00 pm BURNS IN MEDICAL PRACTICE.** A symposium on modern burn therapy is being offered by the Oklahoma Surgical Association. Out-of-state guest speaker will be Charles R. Baxter, MD, Professor of Surgery, Southwestern College, Dallas. His subject will be "Triage, First Aid and Resuscitation." Other topics will include "Modern Burn Therapy in Primary Practice," "Care of Burn Wounds — Major and Minor" and "The Burn Nurse—Solutions to Problems of the Burned Patient and Their Physician." Other guest speakers will include E. Ide Smith, MD; Paul Silverstein, MD; and Ms. M. Victory, RN.
- 2:00 pm ALLERGY.** An afternoon session is being sponsored by the Oklahoma Allergy Society. Topics will include "Clinical Applications of Newer Immunologic Procedures" and a panel discussion on "Bronchial Asthma — What's New!"
- 2:00 pm ADVANCES IN PERINATOLOGY.** Four physicians will make up a special program sponsored by the Oklahoma Society of Pediatrics. Sheldon B. Korones, MD, Professor of Pediatrics, University of Tennessee College of Medicine, Memphis, will be a featured out-of-state speaker. He will be joined by LeRoy C. Mims, MD, and John J. VanHoutte, MD, both of Oklahoma. Topics will include "Respiratory Distress Syndrome — Recognition, Management, and Pitfalls," "Metabolic Adjustments in High Risk Newborns," "Radiological Interpretations of Infants at High Risk and Respiratory Distress Syndrome" and "Results of Management of High Risk Infants Treated in Intensive Care Units."

- 5:00 pm** **DOUBLEHEADER PARTY.** Oklahoma Medical Summit '75 is putting on a doubleheader party on Thursday afternoon. A Keg and Oyster Party is being sponsored by Marion Laboratories. At the same time there will be a Wine and Cheese Tasting Party. Both will be in the Lincoln Plaza Hotel's Congress Room.

Friday Morning, April 25th

- 9:00 am** **OSMA HOUSE OF DELEGATES.** The closing session of the OSMA's House of Delegates will be held Friday morning in the Lincoln Plaza Hotel's Lincoln Room. Election of officers and final consideration of all reports and resolutions will be the order of business.
- 9:00 am** **CANCER OF THE PROSTATE.** A full-day seminar on cancer is being sponsored by the Oklahoma Division and Oklahoma County Unit of the American Cancer Society. The morning will be devoted to cancer of the prostate. Out-of-state speakers include George T. Mellinger, MD, Chief of Urology, Veteran's Administration Hospital, Wichita, Kansas and Donald F. Gleason, MD, Professor of Pathology and Laboratory Medicine, University of Minnesota, Minneapolis. Topics to be covered in the morning include "Approach Toward International Classification of Carcinoma of the Prostate . . .," "National Cooperative Studies of Carcinoma of the Prostate," "Combined Pathological Grading and Clinical Staging Relative to Prognosis in Carcinoma of the Prostate," "Radiation Therapy — A Curative Modality," and "Oklahoma Regional Study of Carcinoma of the Prostate."
- 9:00 am** **PSYCHIATRY SEMINAR.** The Oklahoma District Branch of the American Psychiatric Association is sponsoring a potpourri program for psychiatrists. Topics will include "Cardiovascular and Neuroendocrine Concomitants of Sleep States," "Use of Hypnosis in Medical Practice: Shall We Lose Sleep Looking for Prescription Drugs to Induce Sleep?," "Pharmacokinetics and the Faith of Psychoactive Medication in Body Systems: Steps Toward a Rational Use of Drugs," "Side Effects of Drugs Commonly Used for Nervousness" and a special lecture on "Challenges and Strategies in the Rational Treatment of Depression." This last will be given by George N. Simpson, MD, Principal Research Scientist, Rockville State Hospital, Orangeburg, New York.
- 12:00 noon** **SUPERSTAR LUNCHEON.** One of the nation's most sought-after physician speakers will be featured at the Friday Luncheon. Phillip Thorek, MD, will be the guest speaker.

Friday Afternoon, April 25th

- 1:30 pm** **ACUTE MYOCARDIAL INFARCTION.** An afternoon session devoted to new concepts in the managements of MI is be-

ing sponsored by the Oklahoma Heart Association. The all-Oklahoma physician panel will discuss such topics as "New Efforts to Diminish the Magnitude of Muscle Necrosis in the Management of Acute Myocardial Infarction," "Cardiogenic Shock — Definition and Management," "Invasive and Noninvasive Monitoring in the Coronary Care Unit," "Ventricular Arrhythmias in the CCU — Do All of Them Need Therapy?," "Bradyarrhythmias in the CCU — Which Ones Require A Temporary Pacemaker?" and the session will end with a question and answer panel discussion.

- 2:00 pm** **CANCER SEMINAR.** The afternoon portion of the American Cancer Society's program will feature three out-of-state speakers: Gordon F. Schwartz, MD, Associate Professor of Surgery and Director of Clinical Services, Breast Diagnostic Center, Jefferson Medical College, Philadelphia; Lee B. Stevenson, MD, Chief of the Division of Obstetrics and Gynecology, Grace Hospital, Detroit; and C. G. Coin, MD, Radiology Associates in Albuquerque, New Mexico. Topics will include "Detection and Treatment of Early Breast Cancer," "Cancer of the Uterus," "Computerized Axial Tomography in Brain Tumors," "Experience with Trans-Bronchial Biopsy" and "Flexible Fiberoptic Bronchoscopy in the Diagnosis of Lung Carcinoma."
- 2:00 pm** **RENAL PATHOLOGY.** "Some Myths of Chronic Pyelonephritis" will be the subject of a lecture by Robert H. Heptinstall, MD, Chairman of the Department of Pathology, The Johns Hopkins School of Medicine, Baltimore. The session is being sponsored by the Oklahoma State Association of Pathologists.
- 6:30 pm** **PRESIDENTS' DINNER-DANCE.** The presidents and presidents-elect of the three sponsoring organizations for Oklahoma Medical Summit '75 will host the annual Presidents' Dinner-Dance on Friday Evening. It will start at 6:30 pm with a cocktail reception in the Lincoln Plaza Hotel Congress Room. At 7:00 pm dinner will be served in the Lincoln Plaza Playhouse (the play will not be offered this evening). The official ceremonies will be kept brief and a dance will start at 8:30 pm. Music will be furnished by the Forrest Wasson Orchestra. Tickets are \$15 per person.

Saturday Morning, April 26th

- 8:30 am** **HYPERLIPOPROTEINEMIAS.** Oklahoma's Medical Research Foundation is sponsoring a half-day program on "Clinical Significance of the Hyperlipoproteinemias and Their Management." Out-of-state guest speaker will be William R. Hazzard, MD, Director, Northwest Lipid Research Clinic, Seattle, Washington. His topic will be "Treatment of Hyperlipoproteinemias." Other topics will include "The Clinical Significance of the Hyperlipoproteinemias," "Cardiovascular Diagnosis and its Role in Evaluation of Hyperlipoproteinemias" and a panel discussion on "Diagnostic and Therapeutic Problems of the Hyperlipoproteinemias."

- 8:30 am ANESTHESIOLOGY.** The Oklahoma Society of Anesthesiologists has invited Herman Turndorf, MD, Professor and Chairman of the Department of Anesthesiology, New York University School of Medicine to be their guest speaker. His subject will be "Anesthesia for Ophthalmic Surgery," and "Tracheal Lesions Following Airway Intubation."
- 9:00 am ORTHOPEDICS AND RHEUMATISM.** The Oklahoma Orthopedic Society and the Oklahoma Rheumatism Society will combine to offer a half-day program on such topics as "Arthroplasty of the Hip and Knee," "Care of Acute Injuries of the Hand," "Athletic Injuries of Soft Tissue," "Polymyalgia Rheumatica," "Dermatomyositis and Polymyositis" and "Rheumatoid Arthritis." Out-of-state speakers will be Charles A. McKenna, MD, Assistant Professor of Medicine, Mayo Clinic, Rochester, Minnesota; and Robert H. Persellin, MD, Professor of Medicine and Chairman of the Division of Rheumatology, University of Texas Medical School, San Antonio.
- 9:00 am UROLOGY.** The Oklahoma State Urological Association will sponsor a discussion of such topics as "Stage D Carcinoma of the Prostate," "Correlation of Metastasis with Pathological Grade and Clinical Stage," "Orchiectomy and Estrogens; the Veteran's Administration Experience," "Hypophysectomy," "Cytosan and Other Drugs" and "Radiation Therapy, Including P-32."
- 11:30 am SUPERSTAR LUNCHEON.** Saturday's Superstar Luncheon will feature two outstanding speakers: Governor David L. Boren of the State of Oklahoma and Joe T. Nelson, MD, American Medical Association Trustee. Luncheon tickets are \$5 per person.

Saturday Afternoon, April 26th

- 1:30 pm PHOTOGRAPHY SEMINAR.** A special seminar for amateur photographers will be conducted by an Oklahoma City commercial photographer, David Fitzgerald, and an amateur international salon exhibitor, Raymond Riggs. They will discuss all aspects of amateur photography.
- 2:00 pm PSRO.** Guest speaker at this special meeting will be Henry E. Simmons, MD, MPH, Director of HEW's Office of Professional Standards Review. His presentation will be followed by a panel discussion featuring Joe T. Nelson, MD, American Medical Association Trustee; Herbert A. Holden, MD, American Academy of Family Physicians President; and Doctor Simmons.
- 5:00 pm ORTHOPEDICS AND RHEUMATISM.** This is a continuation of the morning program sponsored by the Oklahoma Orthopedic Society and the Oklahoma Rheumatism Society. Two topics will be discussed, "Work in Progress: Rheumatology at the Mayo Foundation" and "Research Project Report." ☐

Summit '75 Entertainment



Joseph Cotton

DOUBLEHEADER PARTY

5:00 pm—Thursday, April 24th

The Summit '75 doubleheader will be a Keg and Oyster Party combined with a Wine and Cheese Tasting Party. Marion Laboratories will sponsor the Keg and Oyster portion of the affair and will dish out delicacies from the briney deep and cooling brew. For those with a more refined pallet, wine and cheese will be available.

The party starts early so there will be time for a night on the town, specialty dinners, or alumni functions.

EARLY BIRD PARTY

6:00 pm—Wednesday, April 23rd

Medical Summit's Early Bird Party will feature a cocktail reception at 6:00 pm followed by dinner and a play at 7:00 pm in the Lincoln Plaza Playhouse. The play for the evening will be "The Reluctant Debutante" starring Joseph Cotton. Tickets for the Early Bird Party are \$12.50 per person.

PRESIDENTS' DINNER-DANCE

6:00 pm—Friday, April 25th

The Presidents' Dinner-Dance will honor the outgoing and incoming presidents of Oklahoma Medical Summit's three sponsoring organizations: The Oklahoma Academy of Family Physicians, Oklahoma City Clinical Society, and the Oklahoma State Medical Association. Cocktails and hors d'oeuvres will be featured from 6:00 until 7:00 pm, in the Lincoln Plaza Hotel's Congress Room. This will be followed by dinner in the Lincoln Plaza Playhouse (the play will not be offered this evening.) A gourmet menu has been arranged and will be served with appropriate wine. The official ceremonies for the evening will be brief and followed, at 8:30 by a dance. Music will be furnished by the Forrest Wasson Orchestra. Tickets for the function are \$30 per couple (\$15 per person). □

Summit Superstar Luncheon Speakers

Three nationally recognized experts from the socioeconomics of medical care will be luncheon speakers during Oklahoma Medical Summit '75. Each luncheon will start at 12 noon, Thursday through Saturday, in the Lincoln Plaza Forum Room (downstairs). Tickets are \$5 per person, per luncheon.



THURSDAY LUNCHEON
SPEAKER, HERBERT HOLDEN, MD

Doctor Holden is the current President of the American Academy of Family Physicians.



FRIDAY LUNCHEON
SPEAKER, PHILLIP THOREK, MD

Doctor Thorek is one of the most sought after physician-speakers in the United States. He is director of Medical Education for the American Hospital in Chicago.



SATURDAY LUNCHEON
SPEAKERS, GOVERNOR DAVID L. BOREN AND JOE T. NELSON, MD

The Saturday luncheon will feature two speakers. Governor David L. Boren (left), Governor of the State of Oklahoma, will join Joe T. Nelson, MD, American Medical Association Trustee. Doctor Nelson is an internist in general practice in Weatherford, Texas. □

AGENDA*

House of Delegates Meeting

ANNUAL MEETING—OPENING SESSION

2:30 pm, Wednesday, April 23rd, Lincoln Room, Lincoln Plaza Hotel

- | | |
|-------------------------------------|-----------------------------------|
| I. Call to Order | VII. Board of Trustee's Report |
| II. Report of Credentials Committee | VIII. Treasurer's Report |
| III. Introduction of Guests | IX. Council and Committee Reports |
| IV. Remarks of Speaker | X. Introduction of Resolutions |
| V. Nominations for Elections | XI. Necrology Report |
| VI. Report of the President | |

(Reference Committees will meet at 8:00 am on Thursday morning, April 24th, in the Lincoln Plaza Forum Building.)

ANNUAL MEETING—CLOSING SESSION

9:00 am, Friday, April 25th, Lincoln Room, Lincoln Plaza Hotel

- | | |
|-------------------------------------|----------------|
| I. Call to Order | IV. Elections |
| II. Report of Credentials Committee | V. Adjournment |
| III. Reference Committee Reports | |

**Condensed version subject to modification*

OFFICERS TO BE ELECTED

President-Elect (one-year term)
Vice-President (one-year term)
Secretary-Treasurer (two-year term)
Delegate to AMA, position three (two-year term)
Alternate Delegate to AMA, position three (two-year term)
Trustees from District XI through XIV (three-year term)

Photo Contest and Photography Seminar

Physicians and spouses interested in photography are invited to enter the Oklahoma Medical Summit '75 Photo Contest to be held during the April 23rd-26th meeting in the Lincoln Plaza Forum.

In addition to the contest, there will also be a Photography Seminar on Friday afternoon, April 26th for amateur photographers. The seminar will be taught by Mr. Raymond Riggs, an international amateur salon exhibitor, and Mr. David Fitzgerald, a commercial photographer in Oklahoma City. The two men will present a formal program and then leave time for questions and answers.

The rules for the photography contest are as follows:

Rule 1: All entrants must be members of at least one of the sponsoring organizations of Oklahoma Medical Summit (OAFP, OCCS, or OSMA) or the spouse of a member.

Rule 2: Entries may be either black and white or color *prints* with a minimum size of 5 x 7 inches up to a maximum size of 16 x 20 inches.

All photos must be mounted or framed. (Sorry, no slides or transparencies.)

Rule 3: Photos may be of any subject matter: portrait, scenic, general interest, scientific, etc.

Rule 4: All entries must be in the Oklahoma State Medical Association office no later than Monday, April 21st. . . or entries may be brought to the Lincoln Plaza Forum Building on Wednesday afternoon, April 23rd.

Rule 5: Each entry must be clearly marked so that its ownership may be easily ascertained. All photos will be returned to their owners after the Oklahoma Medical Summit meeting, or they may be picked up on Saturday afternoon, after 4:00 pm, April 26th.

Rule 7: First, second, and third place awards of \$75, \$50 and \$25 gift certificates will be made for the best three black and white and three color photos.

All entries should be shipped to Oklahoma State Medical Association, Attention Ed Kelsay, 601 Northwest Expressway, Oklahoma City, Oklahoma 73118. ☐

Oklahoma State Medical Association

1975 Delegates and Alternates

SOCIETY

ALFALFA-WOODS
ATOKA-BRYAN-COAL
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BLAINE
CADDO
CANADIAN
CARTER-LOVE-
MARSHALL
CHOCTAW-
PUSHMATAHA
CLEVELAND-McCLAIN

COMANCHE-COTTON-
TILLMAN

COOKSON HILLS
(Cherokee, Adair &
Sequoyah)

CRAIG-OTTAWA-
DELAWARE

CREEK
CUSTER
EAST CENTRAL

GARFIELD

GARVIN-MURRAY
GRADY
GREER-HARMON
HUGHES-SEMINOLE
JACKSON

JEFFERSON
KAY-NOBLE
KINGFISHER
KIOWA/WASHITA
LeFLORE-HASKELL
LINCOLN

LOGAN
McCURTAIN

NORTHWEST
(Beaver, Dewey, Ellis,
Harper & Woodward)

OKFUSKEE
OKLAHOMA

DELEGATE

John X. Blender, MD
(Not Reported)
Wm. M. Leebron, MD
Billy Dale Dotter, MD
Arvin C. Roberson, MD
Edgar W. Young, MD
David P. Rose, MD
Edward E. Velayos, MD
(Not Reported)

Chester L. Bynum, MD
James B. Silman, MD
Hayden H. Donahue, MD
Robert Hillis, MD
Jack D. Honaker, MD
Samuel C. Jack, MD
William Z. Cook, Jr., MD

Yale E. Parkhurst, MD

(Not Reported)
James Harold Tisdal, MD
Edward H. Fite, Jr., MD
M. C. Gephardt, MD
Harvey P. Randall, MD
Edward L. Leonard, MD
Joseph W. Stafford, MD
Joe B. Jarman, Jr., MD
Frank L. Adelman, MD
John W. Ellis, MD
J. William McDoniel, MD
Wade Norman, MD
Jack W. Parrish, MD
Charles L. Tefertiller, MD
Malcolm Mollison, MD
(Not Reported)
Edwin C. Yearly, MD
Jack L. Berry, MD
(Not Reported)
R. L. Winters, MD
(Not Reported)
Robert F. Ringrose, MD
(Not Reported)
(Not Reported)

(Not Reported)
Donald D. Albers, MD
Charles Atkins, MD
H. Thompson Avey, MD
Jack H. Barney, MD
Wm. G. Bernhardt, MD
Karl K. Boatman, MD
Kent Braden, MD

ALTERNATE DELEGATE

Ed L. Calhoon, MD
(Not Reported)
(Not Reported)
Claude H. Williams, MD
James A. Hill, MD
James P. Jobe, MD
Winfred L. Medcalf, MD
J. Hobson Veazey, MD
(Not Reported)

Frank H. Cooper, MD
James S. Wall, MD
John G. Rollins, MD
J. Paul Reimer, MD
William S. Davies, MD
C. Victor Williams, MD
Clifford A. Traverse, MD

(Not Reported)

(Not Reported)
John M. Huser, MD
Jesse S. Chandler, MD
Tom G. Hodge, MD
David F. Watson, MD
Wm. S. Dandridge, MD
Earl M. Robinson, MD
Gene Stunkle, MD
Paul A. Leap, MD
James H. Lindsey, MD
(Not Reported)
Phillip N. Kingery, MD
Claude B. Knight, MD
Noble Ballard, MD
Noble Ballard, MD
(Not Reported)
E. Edwin Fair, MD
Kenneth Evans, MD
(Not Reported)
C. D. Cook, MD
(Not Reported)
J. R. Henke, MD
(Not Reported)
(Not Reported)

(Not Reported)
Martin H. Andrews, MD
Schales L. Atkinson, MD
A. Stanley Bailey, MD
Paul A. Bennett, MD
R. LeRoy Carpenter, MD
Wm. O. Coleman, MD
William J. Craig, MD

	Earl Bricker, MD	M. Joe Crosthwait, MD
	Irwin H. Brown, MD	Ernest R. Daffer, MD
	R. Barton Carl, MD	W. Edward Dalton, MD
	Donald R. Carter, MD	Ronald C. Elkins, MD
	Charles W. Cathey, MD	Robert S. Ellis, MD
	Wm. R. Cleaver, MD	Paul D. Erwin, MD
	Charles E. Delhotal, MD	James D. Funnell, MD
	Richard G. Dotter, MD	James R. Geyer, MD
	John W. Drake, MD	James F. Hammarsten, MD
	Arthur F. Elliott, MD	James W. Hampton, MD
	Warren L. Felton, II, MD	Charles M. Harvey, MD
	Thomas H. Henley, MD	George R. Jay, MD
	Elwood Herndon, MD	Edmond H. Kalmon, MD
	Wm. E. Hood, Jr., MD	Neil B. Kimerer, MD
	Daniel M. Lane, MD	Robert D. Lindeman, MD
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DEATH

W. ARTHUR HYDE, MD
1901-1975

A long-time Durant surgeon, W. Arthur Hyde, MD, 73, died February 27th, 1975. A native of Cleburne, Texas, Doctor Hyde was graduated from the University of Texas School of Medicine in 1926. After practicing in Galveston, Doctor Hyde established his practice in Durant where he remained until his retirement in 1971.

Active in both medical and civic affairs, Doctor Hyde had served as President of the Atoka, Bryan, Coal County Medical Society and as a Councillor to the Oklahoma State Medical Association. His medical affiliations include the American College of Surgeons and the International College of Surgeons. □

Book Reviews

Care of the High Risk Neonate. By M. H. Klauss and A. A. Fanaroff. 358 pp. Philadelphia: W. B. Saunders Co., 1973

Neonatal care has been one of the most rapidly advancing areas of pediatrics for the last 15 years. Several books have appeared recently in response to an obvious need for practical guidance on the management of the sick newborn infant. This book was conceived as an attempt to introduce house officers, medical students, and nurses to the different requirements of the care of newly born infants. The format is quite different from that of a standard textbook in that each chapter is devoted to a practical problem such as assisted ventilation, neonatal infection, and others. The chapters begin with a discussion of the physiologic background of the subject followed by a list of practical considerations. There is then a summary of the features of the chief disease which causes the problem and the discussion and this is followed by a detailed guide to management.

A further lively feature of the book is the frequent inclusion of comments on the text by other experts. That these sometimes contradict what has just been said may sound confusing; however, it is an effective way of indicating the uncertain and controversial parts of neonatal care. The text also contains many useful graphs

and illustrations. The appendix is 48 pages long and contains a list of normal values for newborns, growth charts, and guides to assessments of various problems.

This is a very useful book and is to be recommended. *Harris D. Riley, Jr., MD*

Genetic Disorders of the Endocrine Glands. By David L. Rimoim and R. Neil Schimke, pp 383, C. V. Mosby Company, St. Louis, Missouri, 1971. \$32.50

This book is divided into nine chapters which catalogue the various endocrinopathies which have a proved or suspected genetic basis. The first chapter, "The Genetic Aspects of Clinical Endocrinology" outlines the mechanisms of gene action and modes of inheritance pertinent to endocrinologic abnormalities. Thereafter each chapter discusses the anatomy, embryology, and normal function of a particular endocrine gland such as the anterior pituitary, pancreas, thyroid, etc.

A particularly interesting and informative section is that on the genetics of diabetes mellitus.

The main defect of the book is the brevity with which many of the subjects are treated. Only the most salient facts without a thorough discussion is offered. Because of the highly specialized topic, the book will be of little direct benefit to the practicing pediatrician or medical student, but will be of interest to those involved in the clinical and research aspects of endocrinology and metabolism. *Harris D. Riley, Jr., MD*

Human Prolactin: Proceedings of the International Symposium on Human Prolactin, Brussels, June 12-14, 1973. Edited by J. L. Pastels and C. Brobin. New York: American Elsevier Company. 340 pp. Price \$32.50.

This monograph contains 33 papers and discussions from the Proceedings of the International Symposium on Human Prolactin held in Brussels in June 1973. These concern chemistry, morphology, receptors, assay methods, comparative physiology of secretion, pathophysiology of secretion in humans, mammary carcinogenesis, and pharmacology. The focus is chiefly on investigative interests. This monograph will be of interest only to those concerned with this topic. *Harris D. Riley, Jr., MD* □

The **JOURNAL** May 1975 Vol. 68, No. 5
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ACROMEGALY LURKS!

Growth hormone-producing lesions of the hypothalamic-pituitary axis produce distinctive changes in humans which we recognize as acromegaly. The disease can kill through both its central tumorous effects and through the peripheral hormonal effects on the skeletal and cardiovascular systems. When fully developed, the signs of soft tissue and bony overgrowth are extremely characteristic, but recognition is often delayed for decades, principally because the changes develop so slowly that neither patient, family nor family physician notices the transformation even as it occurs before their very eyes. Unfortunately, bony changes never remit, and destructive changes due to central nervous system tumors may also be irreversible. Early diagnosis is critical if the patient is to be spared acromegalic disfigurement.

Although the cause of acromegaly remains obscure (primary pituitary neoplasia vs hypothalamic dysfunction causing hyperpituitarism), the disease is easily diagnosed by determinations of serum human growth hormone (HGH) concentrations and reliable assays are available from numerous commercial laboratories within easy access to physicians. In view of the seriousness of the disease, the investment in two serum HGH determinations (fasting and two hours after 100 gms of orally administered glucose) is cheap indeed and is to be strongly recommended. (Actual cost approximately \$20 per sample.) In acromegaly, there is failure of the HGH concentration to suppress, after glucose, to less than 5 ng/ml.¹ Fasting HGH levels alone can be misleading be-

cause of the many normal stimuli for HGH release.

Major therapeutic improvements have appeared during the past ten years and all physicians should be aware that acromegaly is a treatable, if not a curable, disease. The successful removal of growth hormone-producing tumors by transsphenoidal hypophysectomy utilizing microdissection methods is particularly impressive,² and newer information clearly shows significant improvement in growth hormone concentrations following external irradiation as well.³ While the long sought for medical treatment is not imminent, agents are known which can ameliorate excessive growth hormone secretion. Both growth hormone inhibiting hormone (somatostatin)⁴ which has been synthesized and is available for research, and bromocryptine,⁵ appear very promising.

Acromegaly is a lurking, indolent, serious illness that should no longer go unrecognized or untreated. *James L. Males, MD, Department of Medicine, Oklahoma City Clinic and Clinical Instructor, Section of Endocrinology, College of Medicine, The University of Oklahoma Health Sciences Center.* □

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I accept the high office of President of the Oklahoma State Medical Association with a deep sense of humility. I accept, too, the deep responsibility that goes with it, and I shall seek your continued help and continued guidance in the months ahead. My fellow physicians, our cause is too great for any one man to feel worthy of it. I promise that during the coming months I will exert tremendous energy and thought to help bring about another successful year. I shall continue to work with and help develop all segments of medicine.



Our state medical association should exist only as it relates to the care of patients, but this must include every aspect of health of the community. We must continue to demonstrate our respect for the patient as a person. We must be able to present our community with educated opinions, and be willing to take a stand on important issues regardless of the popular appeal.

During the past year, the work of our President, Doctor Jack Richardson, has been very outstanding. He has worked with untiring energy and the association owes him a debt of gratitude.

The committees have functioned very commendably during the past year. I want to thank all of you who participated in the committee work, for this is the basis and background of our state medical association. The work of two of our committees, I feel, has been tremendously outstanding.

The Legislative Committee has done a yeoman's job during the past year, under the direction of Doctor Barton Carl and under the staff leadership of Mr. David Bickham. These men, along with the other members of the committee, have done a tremendous job.

The Medical School Liason Committee, headed by Doctor C. S. Lewis, Jr. of Tulsa, has done an outstanding job during the past year.

I want to acknowledge and thank the Auxiliary to the Oklahoma State Medical Association.

tion. Their diligence and untiring work goes on and we do appreciate it.

I want to pledge the Oklahoma State Medical Association's continued support of the Oklahoma Health Sciences Center, and their administration. I want to extend a special welcome to Doctor William Thurman, the new Provost of our Oklahoma Health Sciences Center. Doctor Thurman, we pledge our support in every way, to you, and to our Health Sciences Center.

I want to acknowledge the fine work of our Dean, Doctor Tom Lynn, and his staff, and pledge our continued support of the Oklahoma University Medical School. I want to acknowledge the fine work of our Oklahoma State Health Department. Doctor LeRoy Carpenter and his staff have turned our State Health Department into a responsive and responsible organization, within the medical profession. We are proud of it. We are happy to work with you and we pledge our support.

I am deeply concerned about the Professional Standards Review Organization law and the Utilization Review regulations. These problem areas continue to bother us, and the problems with them continue to change from day to day; but, fellow physicians, whatever the problems may be, let it be the policy of our state association, to fight all government and other third party interference with every method at our disposal. We of the medical profession must continue to support whatever policy can deliver the best medical care possible to our patients of Oklahoma.

If I can leave but one message, let it be one of togetherness and cooperation. I would strongly recommend that we continue cooperation among all physicians throughout our state. We do have some differences of opinion but our overall goals are the same. We must continue to fight for a common goal that will continue to give our patients the best medical care in the world.

Let the practicing physicians, and the physicians of the Oklahoma Health Sciences Center join hands; let all specialists and generalists unite — and work together to make Oklahoma a better place in which to live and a better place in which to practice medicine.

Once again I ask for a cooperative spirit among physicians of our State. If we can join in a truly united front, then success will be ours.

Arnold G. Nelson, M.D.

PEDIATRIC GRAND ROUNDS

Pancreatitis In Children

Participants

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Pancreatitis in children is a relatively uncommon disorder. This article reviews all facets of this disorder with particular emphasis on an unusual form, hereditary pancreatitis.

Doctor Riley: The patient to be presented demonstrates an unusual type of pancreatitis. Of course, pancreatitis of any type in children

is relatively uncommon. Doctor Freed will give us the history, Doctor Poley will discuss topics relevant to pancreatitis, and Doctor Smith will discuss the surgical management of pancreatitis and its complications.

Doctor Freed: The patient is D.A.B., a 14-year-old white girl from northeastern Oklahoma. She was admitted to Children's Memorial Hospital approximately one week ago because of recurrent and severe abdominal pains of several months' duration. Bouts of abdominal pains initially had recurred about every 6 to 12 months since the age of six or seven years. She indicated that the pain was in the epigastric area. There was no associated fever, nausea or vomiting. Abdominal pains initially were relieved by antacids and aspirin. During the past two years, the attacks of abdominal pain have become more frequent and more severe. They were occurring once every six to nine months; and definitely were aggravated by meals, but there was no vomiting and neither the patient nor the mother remember any particular foods which could precipitate an attack. Initially, there was no transmission of pain and there was no history of diarrhea or steatorrhea and no history of anemia. In June 1968, during one of these attacks of abdominal

From the Children's Memorial Hospital, University of Oklahoma Health Sciences Center.

pain, a serum amylase determination was requested by the referring physician; it was elevated to 688u/100 ml (normal up to 160u/100 ml). During 1969, the patient had only one attack and x-ray studies of the upper gastrointestinal tract that summer were normal. In June 1970 a severe attack of abdominal pain occurred. The serum amylase value was 880u/100 ml. This attack lasted about 10 days. She was not hospitalized but was given Demerol and Phenergan parenterally, with some relief. The next attack occurred in August 1970. This was of gradual onset, but the pain increased in intensity, with definite postprandial aggravation. Pain was also worsened by deep inhalation. The pain again was located in the epigastric area, and was transmitted to the back with deep inhalation. In early September 1970, the girl was hospitalized at a local hospital because of another severe attack of pain. At that time she was afebrile, but had an elevated serum amylase value. She was treated with nasogastric suction and anticholinergics. The hospital course was complicated by a bout of upper-GI hemorrhage of moderate intensity and by transient ascites. Serum calcium level was 4.2 mEq/L, and the patient complained of a "soapy taste" in her mouth. She gradually recovered and was dismissed from the hospital on September 16 on a regimen including Donnatal. Although improved, she was not completely free of pain and had lost 14 or 15 pounds. In October, November, and December 1970, attacks of abdominal pain occurred more frequently and the patient was forced to miss a considerable amount of school. In December 1970 there was also transmission of pain around to the left hemithorax and towards the back.

During the past three months, her stools have become loose, frothy, malodorous, and difficult to flush. Postprandial pain became quite common, as did nocturnal pain. Further, pain was also transmitted more frequently to the left shoulder. Pain was best relieved by leaning forward over an object (pillow). Pentazocine (Talwin) was prescribed by her local physician, but it provided little relief. Also, a brief trial of propantheline was not helpful in relieving her pain. There is a strong family history of pancreatitis, which will be discussed later. The rest of her medical and social history is non-contributory. Since no improvement in the

patient's condition could be achieved, she was referred to the pediatric gastroenterology service at Children's Memorial Hospital in December 1970.

On examination, the temperature, pulse, and respirations were normal. Examination of the head, ears, eyes, nose, and throat showed them to be normal, as were the heart and chest. Examination of the abdomen revealed normal bowel sounds, but there was diffuse tenderness to pressure, without localization. The liver could be palpated at the costal margin. There was no splenomegaly, or palpable masses. The genito-urinary system was normal. Neurological findings were also normal. Laboratory data were as follows: Serum amylase values were always elevated and in the range between 1,100 and 1,300 units/100 ml (normal, 60 to 160 units/100 ml). A 24-hour urine amylase value was 6,460 units/100 ml (normal, 38 to 263 unit/100 ml). Serum calcium level was 5.4 mEq/L and alkaline phosphatase was 17 King-Armstrong units; serum glutamic oxaloacetic transaminase was 46 Reitland-Franklin (RF) units (normal, 6 to 40 RF units); bilirubin was normal; total serum protein was 5.8 gm/100 ml, with an albumin of 3.1 gm/100 ml. A fasting blood sugar was 55 mg/100 ml, and an oral glucose tolerance test was normal.

Are there any questions about the history? The x-ray films, including an intravenous cholangiogram, upper GI series, barium enema, and liver scan, will be discussed later by the radiologist.

Doctor Riley: Doctor Poley, do you want to emphasize any features of the history at this point?

Doctor Poley: I would like to emphasize one point. Whereas her abdominal pain had been sporadic, occurring perhaps once or twice a year at most, it became rather continuous and more severe during the past three months. Actually, abdominal pain was one of the most persistent symptoms.

Doctor Riley: Doctor Altman will discuss the x-rays now.

Doctor Altman: Several examinations were done. The patient had a normal chest x-ray. The intravenous cholangiogram was a beautiful example of a normal study. The gallbladder opacity, the cystic duct, the hepatic ducts, and the common bile duct were of normal caliber and there was a normal spill of dye into the duodenum, which rules out any obstruction of

the biliary tract. On barium enema, the transverse colon was in normal position and there were no abnormalities. The oblique view of the upper gastrointestinal tract (Fig 1) shows that the stomach is slightly displaced anteriorly and towards the left, and one gets the impression that it is "draping" around a lesion which lies posterior to the stomach. The proximal small bowel shows a normal pattern. Spot films obtained at the time of the upper gastrointestinal series show a normal esophagus and gastroesophageal junction and, on the antral side of the greater curvature, no evidence of a pressure defect. The sweep of the duodenum is normal in configuration and mucosal pattern, without evidence of a lesion in the region of the head of the pancreas. A frontal examination by spot films again showed a slight displacement of the stomach to the left, apparently draping around a lesion causing a pressure defect on the lesser curvature. A liver scan outlined the uptake of the radioactive compound in the liver and thereby outlined the entire liver parenchyma. By superimposing the scan onto plain films, one can now be certain that the lesion displacing the stomach is not liver. Rather, this lesion is compressing the posterior and medial aspects of the stomach and could originate from the tail of the pancreas. In summary, I think there is an extrahepatic, retrogastric mass which is in the location of the tail of the pancreas.

Doctor Poley: We would like to introduce you to the patient now. D.A.B. and Mrs. B. have kindly agreed to come here, and please feel free to ask questions. I have talked with D.A.B. this morning and she was quite distressed about losing her pants, which was due to weight loss. Are there any questions for D.A. or Mrs. B.? D.A., tell us briefly which region of your tummy was most painful.

D.A.B.: Well, most of it was mostly to my left side (epigastric area), and it goes into my back and up to my left shoulder.

Doctor Poley: The pain in the left shoulder — is that something new or have you had it for some time?

D.A.B.: Some time.

Doctor Poley: For how long?

D.A.B.: About a month or two.

Doctor Wenzl: Is there a position she can get into that gives her relief?

D.A.B.: When I bend forward, it helps, just so I lean forward.

Doctor Poley: How did you do that the other day when I saw you in your room?

D.A.B.: I put a pillow in front of my tummy and bent over.

Doctor Poley: She found out that by stooping over, by leaning forward, she could relieve her abdominal pain. This is a very characteristic position assumed by patients with pancreatic type of pain, or pain that emanates from the retroperitoneal area. She was sitting in her bed with her legs crossed. She had a couple of pillows propped in front of her and she was leaning over these pillows. I wish that all of you could have seen it. It is important when taking a history to ask about factors or positions which relieve pain. Any further questions?

Doctor Riley: Did the pain occur frequently at night?

Mrs. B.: That is usually when it would occur. She would feel pretty well when she was going to school, but at night, either about the time she went to bed or in the early morning hours, she would wake up. During several weeks, she awakened at about 2:00 AM with severe pain and usually she would assume the position described, but she would always need additional medication for pain. She has taken several drugs for pain.

Doctor Poley: Thank you.

A Physician: I want to know if the patient had the mumps.

Mrs. B.: I don't remember. Probably not.

A Physician: Is there history of abdominal injury or trauma preceding the onset of this?

Doctor Poley: We could not elicit such history.

(Patient leaves.)

Doctor Poley: As Doctor Riley has mentioned, this patient has a rare and fascinating problem: chronic, hereditary, familial pancreatitis. We believe that history and findings are characteristic enough to suspect a pancreatic pseudocyst: persistent abdominal pain, persistent elevation of serum amylase, and the retrogastric mass are compatible with such a diagnosis, although only one out of ten patients with hereditary pancreatitis develops a pseudocyst.¹ The first epidiascopic projection shows the genealogical tree. (Fig 2) All individuals characterized by a cross have verified pancreatitis. On the mother's side, we find several members afflicted with pancreatitis. A maternal aunt and uncle had pancreatitis; the

TABLE 1: CAUSES OF RECURRENT PANCREATITIS

Biliary tract disease (27%)
Alcoholism (37%)
Trauma
Hyperparathyroidism
Drugs (steroids, morphine derivatives, thiazides, lincomycin, zinc, chemotherapeutic agents — asporaginase)
Hereditary pancreatitis
Infectious diseases
Hyperlipemia
Idiopathic (12%-40%)
Shock organ (burns, allergies)

aunt also developed diabetes during pregnancy. The mother has a male cousin aged 34 years with chronic pancreatitis. The mother is related to kindred "B," which has been reported in the literature.¹ The patient's younger sister also has pancreatitis and her 10-year-old brother probably has the disease, but we have not examined him. The brother has elevated serum amylase values with relatively little discomfort, whereas the sister has severe, recurrent attacks of abdominal pains associated with markedly elevated serum amylase.

I would now like to outline recent ideas about the etiology and the pathogenesis of pancreatitis, then discuss hereditary pancreatitis and pancreatic pseudocysts.

Table 1 summarizes causes of pancreatitis. Biliary tract disease and chronic alcoholism account for most cases of chronic pancreatitis. Trauma is a quite common cause, as are drugs — steroids, morphine derivatives, zinc, drugs used in cancer chemotherapy, and Lincomycin have all been linked to the development of pancreatitis. Then, there is the large category of so-called idiopathic pancreatitis. In various reported series this category accounts for anywhere from 12% to 40% of all acute and chronic pancreatitis. Then, there is hereditary pancreatitis and pancreatitis due to hyperlipemia. Pancreatitis also occurs in the wake of burns: the pancreas could be viewed as a shock organ. It is unsettled whether allergic manifestations could be responsible for pancreatitis. The functional and clinical Marseilles classification of pancreatitis is as follows: (1) acute pancreatitis, acute relapsing pancreatitis; and (2) chronic pancreatitis and chronic relapsing pancreatitis. The obvious difference between (1) and (2) is that persistent disease and prog-



Figure 1. Oblique view of upper gastrointestinal tract.

ressive damage are sequels only of chronic pancreatitis.

Not much is known regarding the pathogenesis of pancreatitis, and many theories are still controversial. Let me briefly summarize some recent thoughts.² The best hypothesis for the pathogenesis of pancreatitis is one which is compatible with known etiological factors, such as biliary tract disease or alcoholism, and which would account also for the idiopathic cases and the other rare but well-recognized entities of pancreatitis. At the same time, such a hypothesis should be able to explain the development of acute and chronic pancreatitis. A reasonable pathogenetic principle in acute pancreatitis is that of autodigestion, and chronic destruction of the organ in chronic pancreatitis.

Now, let us briefly review the possible role of pancreatic enzymes in pancreatitis, as studied in the experimental animal. First, consider the effect of proteolytic enzymes on pancreatic tissue. Trypsin injected in moderate concentrations into the pancreatic ducts of experimental animals caused both edema and hemorrhage, which were due to vascular changes. However, necrosis rarely was present. Such a pattern of

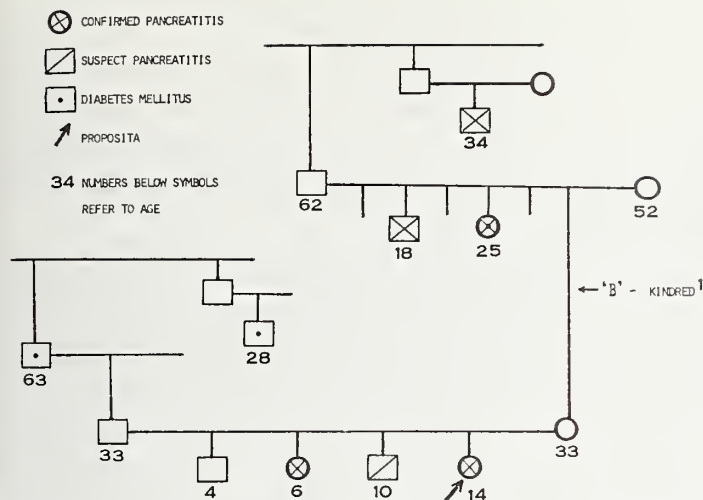


Figure 2. Genealogic tree showing members afflicted with pancreatitis.

inflammation does not correspond to the pattern of acute pancreatitis in man. Furthermore, trypsin, if present in the pancreatic tissue, is rapidly inactivated. Chymotrypsin had an effect similar to that of trypsin.

Next, let us consider the role of elastase. Elastase is an enzyme found in the pancreas and activated by trypsin from pro-elastase. Elastase dissolves elastic fibers, as occur in blood vessels. When elastase was injected into the pancreatic duct of experimental animals, a picture similar to that of trypsin-induced "pancreatitis" emerged, but conspicuous damage was limited to blood vessels. The role of kallikrein has been studied, but its effect on pancreatic tissue has not been fully elucidated. Trypsin activates kallikreinogen to kallikrein, which liberates kallidin and bradykinin. Kallidin and bradykinin are among the most potent vasodilators known, and upon the experimental use of kallikrein, vasodilatation increased vascular permeability and vascular damage occurred; leucocyte invasion was also registered, but pancreatic necrosis and hemorrhage were absent. In summary, then, the experimental use of proteolytic enzymes in animals produced only vascular and capillary changes leading to edema and hemorrhage, and necrosis was not predominant.

Next, let us look at the role of the lipolytic enzymes. Again, most of the experimental data were derived from animal studies. Lipase produced changes similar to those seen in chronic pancreatitis of man — there was fat necrosis, which was particularly augmented in the presence of "activators" such as bile acids. Phospholipase also has been studied extensively. Phospholipase has long been known as the

main catalyst of animal poisons. It is a digestive enzyme secreted by the human pancreas and normally is found in large concentrations there. Phospholipase acts on phospholipids by splitting off one fatty acid, resulting in the production of lysophospholipids. These compounds exhibit very strong cytotoxicity and hemolysis. Lysophospholipids also can be incorporated into enzymes and membranes, altering structure and function of the latter. In relation to the postulated role of biliary reflux in the pathogenesis of pancreatitis, it is of interest that there are relatively large amounts of phospholipids in bile. Further, bile acids certainly could serve as catalysts or activators of lipase as well as of phospholipase. It has also been postulated that trypsin may activate pro-phospholipase, and phospholipase A has been found in increased concentrations in the serum of patients with acute pancreatitis. Other pathogenetic mechanisms have to be considered which promote tissue damage: bacterial toxins or the effects of viruses on membranes.

Figure 3 briefly summarizes the interaction of enzymes in the pathogenesis of pancreatitis. Trypsin activates elastase and phospholipase A, liberating lysophospholipids. Trypsin has to be activated from trypsinogen, and it is not clear how this occurs in the pancreas. Refluxed duodenal contents containing enterokinase could activate trypsin, but this has not been demonstrated. Furthermore, trypsin is destroyed rapidly in tissue, so the presence of a not-yet-identified trypsin stabilizer has to be considered. It is most likely that the combined effects of proteolytic, lipolytic enzymes and vasoactive substances bring about changes seen in acute and chronic pancreatitis, but the exact sequence of events is still unknown.

Hereditary pancreatitis was first described

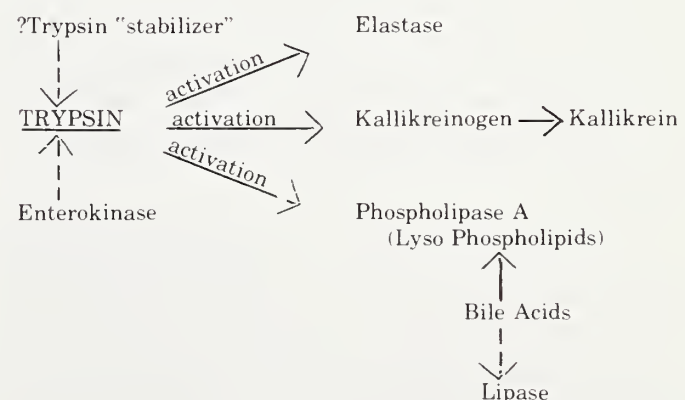


Figure 3. Interaction of enzymes in pathogenesis of pancreatitis.

by Comfort and Steinberg³ in 1952. Hereditary pancreatitis has been identified in the United States, France, Ireland, New Zealand, and the Netherlands. The definition by Gross⁴ is simple and concise: inflammation of the pancreas which is recurrent from early childhood. Hereditary pancreatitis is transmitted as an autosomal dominant trait with some variability in expression and in penetrance, and there is an unusual prevalence among blood-related groups of persons. At the Mayo Clinic, where most of the cases from the United States have been studied, six certain kindreds and 21 possible kindreds have been identified, and about one to three new kindreds are seen each year. We have reports from 22 definite or suspected kindreds from other countries. The nature of the hereditary, predisposing defect is as yet undiscovered. There is no related abnormality recognized as common to all cases of hereditary pancreatitis. Abnormalities of the major pancreatic ducts have been described and implicated in the etiology and pathogenesis, but further studies are required to settle this issue. Aminoaciduria, with particular reference to lysine, cystine, and arginine, has been described in some patients with hereditary pancreatitis, but it occurs also in patients with non-hereditary pancreatitis. Pancreatic calcifications occur in about 40% of patients. They are found mostly in the greater pancreatic ducts. Diabetes and/or exocrine pancreatic insufficiency is found in 20% to 25% of involved persons.⁴

Most patients with hereditary pancreatitis can be managed medically. Surgical intervention is necessary when complications ensue. The prognosis of hereditary pancreatitis generally is good. Carcinoma of the pancreas has been reported in older persons, but there is probably no genetic relationship to hereditary pancreatitis. One of the outstanding findings in hereditary pancreatitis is the absence of significant biliary tract disease and alcoholism.

Pancreatic pseudocysts are an unusual complication. In one study, pseudocysts were recognized in from 2 to 12 patients per 100,000 hospital admissions.⁵ A pseudocyst may be defined as the collection of pancreatic juice confined by a capsule of fibers and granulation tissue devoid of an epithelial lining. A true cyst

always has an epithelial lining. Etiologically, most often there is preceding pancreatitis due either to alcoholism or trauma. Pseudocysts occur in idiopathic as well as in hereditary pancreatitis. A pancreatic pseudocyst has been recognized in about 10% of individuals with hereditary pancreatitis.¹

The symptomatology of a pseudocyst deserves attention: the most common and persistent symptom is abdominal pain. This pain is felt usually in the upper part of the abdomen on the left more often than on the right; pain in the left hypochondrium may be transmitted around the throat to the back, directly to the back, and to the left shoulder more commonly than to the right shoulder. Transmission of pain to the lower abdominal quadrants has also been reported. Other outstanding symptoms are nausea, vomiting, weight loss, and diarrhea, which could be due to the exocrine pancreatic insufficiency. A palpable mass, present in 45% to 75% of patients, usually is felt in the upper part of the abdomen, on the left more frequently than on the right.⁶ Tenderness is present in three out of four patients, but fever, jaundice, and ascites are uncommon. A very common laboratory finding is the persistence of an elevated serum amylase value, which occurs in over 50% of cases. Diabetes is present in about 20% to 25% of patients with pancreatic pseudocyst, but glycosuria and hyperglycemia were found in 50% of one series of 42 patients.⁷

One of the most important tools for the identification of pancreatic pseudocysts is the radiological examination of the upper intestinal tract. In 86% of individuals with a pancreatic pseudocyst, a displacement of the stomach, mostly anteriorly, was noted, but displacement posteriorly can also occur, and there may be widening of the duodenal loop. Frequently, a left pleural effusion is present, and there may be identifiable calcifications within the pancreas. Sometimes a pseudocyst can displace the colon inferiorly. An angiogram, which we originally planned to do in this patient but did not carry out because of her sensitivity to iodinated dyes, would further identify the 50% of pseudocysts which cannot be detected by any other means.⁷ A pseudocyst usually is located anterior to the body of the pancreas, but some unusual locations, such as in the mediastinum or in the perinephric area can occur, and confusion with renal masses is then possible.^{8, 9} A pseudocyst can be complicated by infection and

abscesses, gastrointestinal hemorrhages, and perforations into the stomach, duodenum, or peritoneal cavity. Duodenal obstruction may occur. Portal venous thrombosis has been described, as have hypersplenism, jaundice, gastric ulcerations, and rarely, a colonic fistula.

In summary then, we believe that this girl has chronic hereditary pancreatitis with a pseudocyst most likely complicating her disease. I will return this discussion to Doctor E. I. Smith, who will discuss surgical management.

Doctor E. I. Smith: There are two aspects I would like to discuss. First is the increasing importance of pancreatitis as a differential diagnosis in abdominal pain, and second, the procedures which are available for the treatment of chronic pancreatitis or pancreatic pseudocysts.

Pancreatitis is an important cause of both acute and chronic abdominal pain in childhood. When reviewing the published cases of hereditary pancreatitis, one is struck by the frequency of previous appendectomies, as well as the frequency with which bloody serous abdominal fluid was noted at operation. The upper abdomen cannot be explored properly through a McBurney incision, and I suspect that this is an important reason why pancreatitis is overlooked as a cause of the acute pain. Pancreatitis can result from blunt trauma, and I think that one must equate abdominal pain with a battered child with the possibility of pancreatitis. As in this case of hereditary pancreatitis, the symptoms and signs are rarely characteristic. They are non-specific, and the physician must remember to consider pancreatitis where there is abdominal pain within very broad ranges of signs and symptoms. Consideration of pancreatitis is important in certain high-risk groups of children in whom abdominal pain is frequent, such as patients with congenital spherocytosis, sickle cell disease, or biliary tract disease, and patients receiving steroids or cancer chemotherapy.

Surgery for pancreatitis in children and for pancreatic pseudocysts is concerned with developing good pancreatic flow into the intestinal tract and in overcoming any block to the exocrine flow through the ductal system of the pancreas. In traumatic pancreatitis it is desirable to provide early drainage; this, I believe, will prevent the development of pseudocysts. When a pseudocyst is present, surgical

treatment is indicated. Lastly, there are indications for operation if there is pancreatic lithiasis and particularly if there is evidence of pancreatic ductal obstruction.

In general, the procedures are those of external drainage, internal drainage (either into the stomach or into the loop of jejunum), and pancreatic excision. With pseudocysts the tendency has been to drain these internally, into either the stomach or the jejunum. In the two cases reported by Gerber,¹⁰ there was considerable relief of symptoms by ductal drainage into a loop of jejunum, but this has not been the uniform experience.

The results of drainage of pseudocysts are good, but complications are frequent. One large series showed a recurrence rate of about 7%.¹¹ The Lahey Clinic statistics,¹² which are colored perhaps by the inclusion of some neoplastic cysts, showed a secondary infection rate of 8% and a fistula formation rate of 23%.

Pathologically, the difference between pancreatic cysts and pseudocysts is that the former are lined by epithelium and the latter are not. In the formation of pseudocysts, there is injury to the ductal system and exocrine enzymes are liberated into the tissues surrounding the ductal system but within the general capsule of the pancreas. By enzymatic action, this develops into a cystic loculation which then continues to expand. What we do in this child's case depends on whether or not the cyst communicates with the ductal system and whether it will influence our approach. Some studies suggest that there are intermittent ductal blocks in children with this problem. In draining the pseudocyst a drainage procedure has been employed which may be of some value later.

Doctor Seely: Has there been genetic counseling of the family?

Doctor Poley: I would have to ask Mrs. B. Her brother has been seen at the Mayo Clinic, but I don't know to what extent any members of the family have had genetic counseling.

A Physician: Is hereditary pancreatitis more predominant in females?

Doctor Poley: It is said to occur equally in males and females.

A Physician: Have iso-antibodies against pancreatitis been identified?

Doctor Poley: I have no recollection of this.

A Physician: Would you say that the phospholipids in bile are higher or lower?

Doctor Poley: I mentioned phospholipids in

bile because of the possibility of biliary reflux into the pancreatic ductal system as a cause of pancreatitis: if there is bile reflux, substrate is available for phospholipase to liberate lysophospholipids. □

P. O. Box 26901, Oklahoma City, Oklahoma 73190

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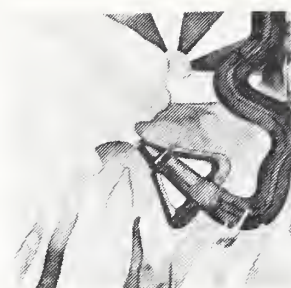
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Hawaii Calling

Over 200 Oklahoman's have now signed up for the OSMA sponsored tour to Hawaii for the AMA's Clinical Meeting.

The tour will depart Oklahoma City November 30 and return December 5. The OSMA package cost \$575 - \$595 for seven nights superior room accommodations at the beautiful Hawaii Regent Hotel on Waikiki and two nights superior room accommodations at the magnificent Maui Surf Hotel on the Valley Island of Maui. It includes roundtrip jet economy airfare from Oklahoma City to Honolulu via Braniff 747 jet and the inter-island airfare.

A \$75 per person deposit is required. If interested, please contact the OSMA immediately, at 601 N. W. Expressway, Oklahoma City, Oklahoma 73118. □



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For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

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Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment of the patient's requirements and tolerance must be made.

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Hypertension in Oklahoma County

S. S. SANBAR, MD, PhD

Results of a limited survey for hypertension emphasize the need to find, follow-up and treat victims in order to reduce morbidity and mortality.

In a 1974 monograph by Doctor Norman M. Kaplan¹ entitled: "Your Blood Pressure: The Most Deadly High — A Physician's Guide to Controlling Your Hypertension," the following is most of the Introduction, which is very appropriate to our study:

30,000,000 Americans have hypertension or high blood pressure.

24,000,000 Americans do not have their hypertension under control. Unless their hypertension is brought under control, they will die 20 years before they should. On the way to their premature death, they will have suffered twice as many heart attacks and four times as many strokes as those whose blood pressures are normal.

15,000,000 Americans don't even know

they have hypertension. Many will find out only after they have suffered a heart attack or stroke.

Hypertension plays a major role in

- *heart failure
- *heart attacks
- *kidney damage
- *strokes

*rupture of major blood vessels

*hardening of the arteries

That's the bad news. Now the good.

*Hypertension can be diagnosed easily without pain and at little expense.

*Hypertension can be controlled, though this takes some trouble and expense.

*When brought under control, hypertension no longer causes premature death or an increased number of heart attacks, strokes, and other vascular diseases.

The challenge is now clear. We can prolong life and prevent disease in a large number of people if we can only recognize and control their hypertension. . . .

The purpose of this article is to depict the blood pressures determined during a hypertension detection drive conducted among Oklahoma County adults, including the employees of the Cities of Oklahoma City and Midwest City, four businesses, two church groups and members of a PTA Convention, during the end of 1973 and the beginning of 1974.

SOURCES OF SUBJECTS AND TECHNIQUE OF BLOOD PRESSURE RECORDING

Table I lists the locations where blood pres-

This Study was supported by the HIGH BLOOD PRESSURE, HYPER-LIPIDEMIA & CARDIOVASCULAR CLINIC, S. S. SANBAR, MD, PhD, Inc., 1211 North Shartel, Oklahoma City, Okla. 73103
Volunteers who conducted the Hypertension Detection Drive: S. S. (Sam) Sanbar, Carolyn Thompson, Eleesa Batdorf, Chantal Sanbar and Jack C. Boling, Sr.

TABLE I — Systolic Blood Pressure Recordings

LOCATION	Total No. of Personnel Tested	Systolic Blood Pressure (mm. of Hg.)		
		140 or Below	145 to 155	160 or Above
		Number and Percent of Total		
1. AMC Discount Store	192	148 (77.1)	37 (19.3)	7 (3.6)
2. St. Patrick Church	199	153 (76.8)	31 (15.6)	15 (7.6)
3. Crown Heights United Methodist Church	87	65 (74.7)	15 (17.2)	7 (8.04)
4. PTA Convention (1973)	258	219 (84.8)	20 (8.7)	19 (7.7)
5. Robberson Steel Co.	257	194 (75.4)	47 (18.2)	16 (6.2)
6. Liberty Bank	432	340 (78.7)	72 (16.6)	20 (5.2)
7. City Employees of Midwest City	245	164 (67.0)	60 (24.5)	21 (8.5)
8. Employees of City of Oklahoma City:				
a) The City	248	200 (80.6)	39 (15.7)	9 (3.7)
b) Police Department	222	171 (77.0)	40 (18.0)	11 (5.0)
c) Zoo	113	79 (70.0)	28 (24.7)	6 (5.3)
d) Water Company	133	88 (66.1)	28 (21.0)	17 (12.9)
e) Sanitary Department	443	267 (60.2)	113 (22.6)	73 (14.2)
f) Airport	104	80 (76.9)	20 (19.2)	4 (3.9)
9. Honeywell Employees:				
a) N.W. Expressway Branch	497	401 (80.7)	87 (17.5)	9 (1.8)
b) S. Portland	406	335 (82.5)	47 (11.6)	24 (5.9)
c) Building No. 5	526	463 (88.0)	48 (9.1)	15 (2.9)
d) Building No. 1	385	305 (79.2)	62 (16.1)	18 (4.7)
All Above Locations	4,747	3,672 (77.6)	794 (16.7)	281 (5.7)

sure recordings were made. A total of seventeen locations comprised the sites. The first seven sites are as indicated, while the employees of the City of Oklahoma City were at six locations, and the Honeywell Employees were at four different locations.

Table I lists also the numbers of personnel tested at each site. All the personnel tested were adults between 18 and 65 years of age. The total number of personnel tested at all seventeen sites was 4,747.

Sitting blood pressure was recorded in the right arm, using two Model 1905 London Presurometers S/N 139. These instruments determine blood pressure electronically and automatically with a direct blood pressure read-out. At least one blood pressure was obtained. In hypertensive patients, two recordings were made, and occasionally blood pressure in the left arm was recorded for confirmation.

RESULTS

Tables I and II show respectively the systolic and diastolic blood pressure. The blood pressures were further subdivided into three subgroups:

- Normal blood pressure: Systolic 140 mm of Hg or below, Diastolic 90 mm of Hg or below,
- Borderline Hypertensives: Systolic 145 to 155 mm of Hg, Diastolic 95 to 100 mm of Hg,
- Hypertensives: Systolic 160 mm of Hg or above, Diastolic 105 mm of Hg or above,

Normal *systolic* blood pressures were obtained in 3,672 (77.6%), while 794 (16.4%) had borderline hypertension and 281 (5.7%) had hypertension. Thus, 22.2% of all subjects tested had systolic blood pressures above 140 mm of Hg. There were some variations in percent of

S. S. Sanbar received his medical degree from the American University of Beirut in 1960 and his PhD degree from the University of Oklahoma in 1963. He is Clinical Assistant Professor at the University of Oklahoma Health Sciences Center. Among his medical affiliations are the American Heart Association, the American Federation for Clinical Research, the American Diabetes Association, the Cardiac Society and the Osler Society.

TABLE II — Diastolic Blood Pressure Recordings

LOCATION	Total No. of Personnel Tested	Diastolic Blood Pressure (mm. of Hg.)		
		90 or Below	95 to 100	105 or Above
		Number (and Percent of Total)		
1. AMC Discount Store	192	167 (87.0)	19 (9.9)	6 (3.1)
2. St. Patrick Church	199	184 (92.4)	13 (6.6)	2 (1.0)
3. Crown Heights United Methodist Church	87	82 (94.2)	4 (4.6)	1 (1.2)
4. PTA Convention (1973)	258	233 (90.3)	16 (6.2)	9 (3.5)
5. Robberson Steel Co.	257	248 (96.4)	6 (2.4)	3 (1.2)
6. Liberty Bank	432	402 (93.0)	18 (4.2)	12 (2.8)
7. City Employees of Midwest City	245	229 (93.5)	11 (4.4)	5 (2.1)
8. Employees of City of Oklahoma City:				
a) The City	248	241 (97.2)	4 (1.6)	3 (1.2)
b) Police Department	222	208 (93.7)	10 (4.5)	4 (1.8)
c) Zoo	113	108 (95.6)	4 (3.6)	1 (0.8)
d) Water Company	133	121 (90.9)	9 (6.8)	3 (2.3)
e) Sanitary Department	443	393 (88.7)	35 (7.9)	15 (3.4)
f) Airport	104	99 (95.3)	4 (3.8)	1 (0.9)
9. Honeywell Employees:				
a) N.W. Expressway Branch	497	476 (95.7)	17 (3.4)	4 (0.9)
b) S. Portland	406	387 (95.3)	13 (3.2)	6 (1.5)
c) Building No. 5	526	510 (96.9)	10 (1.9)	6 (1.2)
d) Building No. 1	385	362 (94.0)	17 (4.4)	6 (1.6)
All above locations	4,747	4,450 (93.7)	210 (4.4)	87 (1.9)

systolic hypertensives in the 17 locations tested, as noted in Table I, with the Water Company, Sanitary Department, the Zoo, and City of Midwest City employees leading in the incidence of elevated blood pressures.

In contrast with systolic blood pressures, the *diastolic* blood pressures were normal in 4,450 (93.7%) of subjects tested. There were 210 (4.4%) with borderline diastolic hypertension and only 87 (1.9%) with diastolic hypertension. The AMC Store and the Sanitary Department had the highest percentage of elevated diastolic blood pressures.

DISCUSSION

It is hoped that the year 1974 will be recorded in the history of American medicine as the year of the nationwide campaign against hypertension. Indeed, May, 1974, was designated as "National High Blood Pressure Month." The American Medical Association, the American Heart Association, the National Medical Association, the Citizens for Treatment of High Blood Pressure, and the US Department of Health, Education and Welfare sponsored and/or endorsed the campaign against hypertension.

The data presented in this article substantiate the existence of a significant group of hypertensive subjects in Oklahoma County (despite the fact that some of those subjects tested were on medications for hypertension). This study compares favorably with numerous other studies.¹⁻⁶ No attempt was made to sort the subjects tested according to weight, height, sex, race, age or what have you. The point of the study is to draw attention to the prevalence of blood pressure elevation in adults in a variety of settings, from the church-goer, conventioneer, hard-hat employees to desk job holders and city employees. "The challenge is now clear," as Doctor N. Kaplan put it. We should recognize hypertension and more importantly, effectively control it to prolong life. We have the means to help hypertensive patients, and it behooves us as physicians to join in the all out effort to control hypertension and minimize its complications.

SUMMARY

The prevalence of elevated systolic and diastolic blood pressures was 22.2% and 6.3% respectively in 4,747 subjects tested, including employees of businesses, the Cities of Okla-

Hypertension / SANBAR

homa City and Midwest City, and church and convention-goers. ☐

1211 North Shartel, Oklahoma City, Oklahoma 73103

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The American Association for CLINICAL IMMUNOLOGY and ALLERGY

The Annual Meeting of The American Association for Clinical Immunology and Allergy will be held at the Riviera Hotel, Palm Springs, California, October 15th-16th, 1975.

Please direct all inquiries to Staff Administrator, Howard Silber, AACIA, P.O. Box 912, DTS, Omaha, Nebraska 402 558-5345.

AMPICILLIN-RESISTANT
HEMOPHILUS INFLUENZAE

Ampicillin-resistant strains of *H. influenzae* have been documented in Oklahoma. The following brief commentary discusses the effect of this occurrence on recommended treatment of bacterial meningitis.

In children more than two months of age *Hemophilus influenzae* type B is the most frequent cause of bacterial meningitis. Until recently, virtually every authority has recommended large doses of ampicillin for initial treatment of meningitis in children before the results of laboratory tests are known. In past months there have been many reports of meningitis in children caused by ampicillin-resistant *H. influenzae*. Ampicillin-resistant organisms still cause only a small fraction of cases of bacterial meningitis. Clinical reports indicate, however, that inadequate treatment of those few patients who do have meningitis with an ampicillin-resistant strain, even for



News From
The Oklahoma State
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Health

one or two days until laboratory reports are available, may result in death or severe neurological damage.

In a recent statement published in *Pediatrics* (55: 145, January 1975), the American Academy of Pediatrics recommends that "in areas where resistant strains have been recognized when *H. influenzae* type B is suspect as the pathogen, initial treatment of bacterial meningitis should include penicillin G or ampicillin, plus chloramphenicol in a dosage of 100 mg/kg/ day." □

REFERENCE

The Medical Letter, Vol. 17, No. 4, February 4, 1975.

COMMUNICABLE DISEASES IN OKLAHOMA FOR MARCH, 1975

DISEASE	March 1975	March 1974	February 1975	Total To Date	
				1975	1974
Amebiasis	—	2	2	3	4
Brucellosis	1	2	—	2	2
Chickenpox	205	279	185	515	414
Encephalitis, Infectious	8	3	—	10	9
Gonorrhea (Use Form ODH-228)	1046	1032	921	2965	2400
Hepatitis, A, B, Unspecified	87	100	68	256	308
Leptospirosis	—	—	—	—	—
Malaria	—	—	1	1	1
Meningococcal Infections	4	2	2	8	7
Meningitis, Aseptic	2	1	1	8	9
Mumps	24	134	15	56	208
Rabies in Animals	15	13	12	39	29
Rheumatic Fever	—	1	—	1	3
Rocky Mountain Spotted Fever	—	—	—	1	—
Rubella	10	5	4	56	18
Rubella, Congenital Syndrome	—	—	1	1	1
Rubeola	5	5	9	15	11
Salmonellosis	13	13	11	46	49
Shigellosis	19	4	17	139	29
Syphilis, Infectious (Use Form ODH-228)	7	21	9	29	45
Tetanus	—	—	—	—	—
Tuberculosis, New Active	43	27	28	88	65
Tularemia	—	1	—	—	2
Typhoid Fever	—	—	—	—	—
Whooping Cough	2	1	1	3	5

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Medical Summit '75 was cited as the "best" meeting they had ever attended by numerous physicians during the four-day meeting. The combined annual meeting of the Oklahoma State Medical Association, Oklahoma Academy of Family Physicians, and Oklahoma City Clinical Society attracted over 2,500 persons.

Held April 23rd-26th in Oklahoma City's Lincoln Plaza, Oklahoma Medical Summit '75 set an attendance record for physicians, when it registered 846 MD's. In addition, 95 medical students and 818 members of allied health groups registered.

During the four-day meeting Oklahoma physicians could choose from over 70 hours of medical and scientific lectures. In addition, they could view nearly 100 scientific, technical, pharmaceutical and business exhibits.

Almost all of the social functions were "sell-out" crowds. In addition, the Superstar Luncheons attracted nearly 250 persons each, with the exception of the Saturday luncheon which attracted over 350 persons. On Saturday, Governor David Boren was the guest Luncheon Speaker along with Joe Nelson, MD, AMA Trustee from Weatherford, Texas.

Plans have already begun for Oklahoma Medical Summit '76! □

Utilization Review Regulations Incur Delegates' Rath

The new regulations regarding Utilization Review that were published November 29th, 1974, by the Secretary of Health, Education, and Welfare were described as "blatant attempts to ration health care and to close America's rural hospitals" by numerous speakers during debate on a resolution not to participate in such reviews.

Three resolutions calling for non-participation in the new regulations were pre-

sented to the OSMA House of Delegates for its consideration. The resolutions were thoroughly discussed by a reference committee of the house on Thursday, April 24th. Following numerous speakers, the reference committee recommended that the house disregard the three resolutions, and consider a substitute resolution in their place.

During debate before the full House of Delegates on Friday, April 25th, the substitute resolution was amended, and finally adopted, as follows:

UTILIZATION REVIEW POSITION

Whereas, the published regulations appearing in the Federal Register on November 29th, 1974 implementing Utilization Review are inconsistent with good patient care, infringe on the doctor-patient relationship, threaten the confidentiality of that relationship, constitutes unsolicited and therefore unethical consultation, promulgate the deterioration of quality medical care, pose the potential threat of closing many hospitals and threaten our patients with possible loss of hospital privileges and financial assistance, and

Whereas, Peer Review and Utilization Review has been traditionally performed by the profession to assure quality medical care, not cost control, and is best handled at the local level so that it can take into consideration local problems, and

Whereas, any nationwide method of Utilization Review must necessarily ignore such local problems and cannot be accurately varied into size of hospital facility of medical staff, and

Whereas, any such national scheme will result only in a rationing of health care services to patients, therefore be it

Resolved, that the physicians of the State of Oklahoma vigorously support the American Medical Association's lawsuit against these onerous regulations and, therefore be it

Resolved, that the physicians of the State of Oklahoma will continue Utilization Review and Peer Review on an individual hospital basis, and will not participate in Utilization Review as outlined in the above cited regulations, and

Whereas, the Oklahoma State Medical Association recognizes that this stance will require a public relations campaign to inform the general public as to the necessity for this position, now therefore be it

Resolved, that the House of Delegates of the

Oklahoma State Medical Association authorize the OSMA Board of Trustees to institute a voluntary assessment to establish an adequate public relations campaign budget should this become necessary, and therefore be it further

Resolved, that the Oklahoma State Medical Association seek the broadest possible base of support in such a campaign by inviting the cooperation of physicians in other medical associations throughout the United States, and be it further

Resolved, that the Oklahoma Congressional Delegation be apprised of the content of this resolution.

Immediately after the House of Delegates adjourned on Friday, a special meeting of the OSMA Board of Trustees was called to appoint an Ad Hoc Committee to supervise the campaign called for in the resolution. The committee immediately began by contacting a professional public relations consultant, Mr. Chuck Schnake of Tulsa, and asked him to prepare a budget for presentation to the OSMA Board of Trustees at a later date. In addition, the committee worked out a tentative plan of action.

One of the first actions of the committee was to authorize the OSMA Staff to notify all other state medical associations of the position taken by the OSMA and to forward to them a copy of the OSMA's resolution. In addition, all members of the association were notified of the action and sent a copy of the resolution.

In a letter to the other state medical associations, Arnold G. Nelson, MD, OSMA President, stated, "Oklahoma physicians have taken a firm position in opposition to the Utilization Review process mandated by Secretary Weinberger in the Federal Register, November 29th, 1974. By an overwhelming vote of 141-2 our House of Delegates adopted the attached resolution.

Doctor Nelson then went on to state that this position was taken after considerable deliberation and then pointed out that 42 rural hospitals in Oklahoma could possibly close as a result of implementing the regulations. He stated, "In our larger institutions the result would be the denial of benefits to many of our patients.

"The inflexibility of Secretary Weinberger's position about modifying the regulations to accommodate the unique characteristics of different geographic areas is an indication that he neither understands nor sympathizes with local problems. We have received considerable help from our Governor and we are supported

in our position by the Director of the Department of Institutions, Social and Rehabilitative Services and by the Commissioner of our State Department of Health.

"We sincerely urge that your association adopt a resolution similar to the one attached. We recognize that this is a national effort and if we are to succeed, we will need a broad base of support."

The President then went on to offer to send a representative to any annual meeting of any state medical association to explain the Oklahoma position.

In a letter to all members of the association President Nelson said, "It is the intention of your association to do everything in its power to see that these regulations are rescinded.

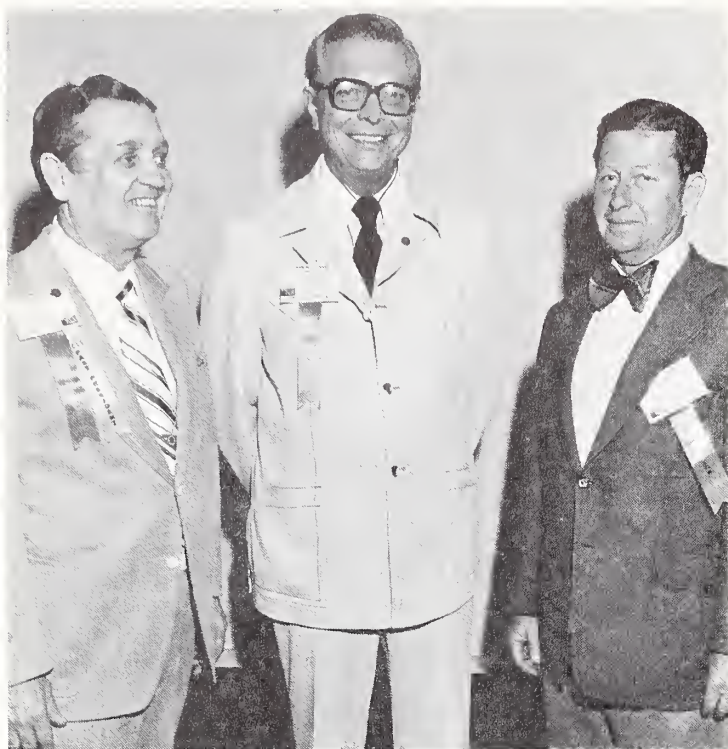
"It is our intention to mount a public relations campaign that will point out that these regulations are a blatant attempt to ration health care under the guise of 'cost controls' and that their implementation will result in the closing of many of Oklahoma's small hospitals."

In closing his letter to OSMA members, Doctor Nelson asked that the physician "join with us by not participating in the new Utilization Review Regulations. Please understand that it is still incumbent upon us, as physicians, to do our own Utilization and Peer Review in individual hospitals and to continue doing Utilization Review under the old method." □

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David L. Boren, (below) Governor of the State of Oklahoma, addresses Oklahoma Medical Summit '75 on Saturday afternoon, April 26th.



Arnold G. Nelson, MD, (left) assumed leadership of the state's largest medical group, the OSMA. Orange M. Welborn, MD, Ada, (center) took over the reins as President-Elect of the state association. William M. Leebron, MD, a general surgeon from Elk City, became Vice-President of the group.

Below are the Past-Presidents of the OSMA who attended the annual breakfast in their honor. Left to right are: Stanley R. McCampbell, MD, Oklahoma City; George H. Garrison, MD, Oklahoma City; Clinton Gallaher, MD, Shawnee; J. Hoyle Carlock, MD, Ardmore; Jack L. Richardson, MD, Tulsa, OSMA President; Hillard Denyer, MD, Bartlesville; Ed Calhoun, MD, Beaver; Scott Hendren, MD, Oklahoma City and, Harlan Thomas, MD, Tulsa.





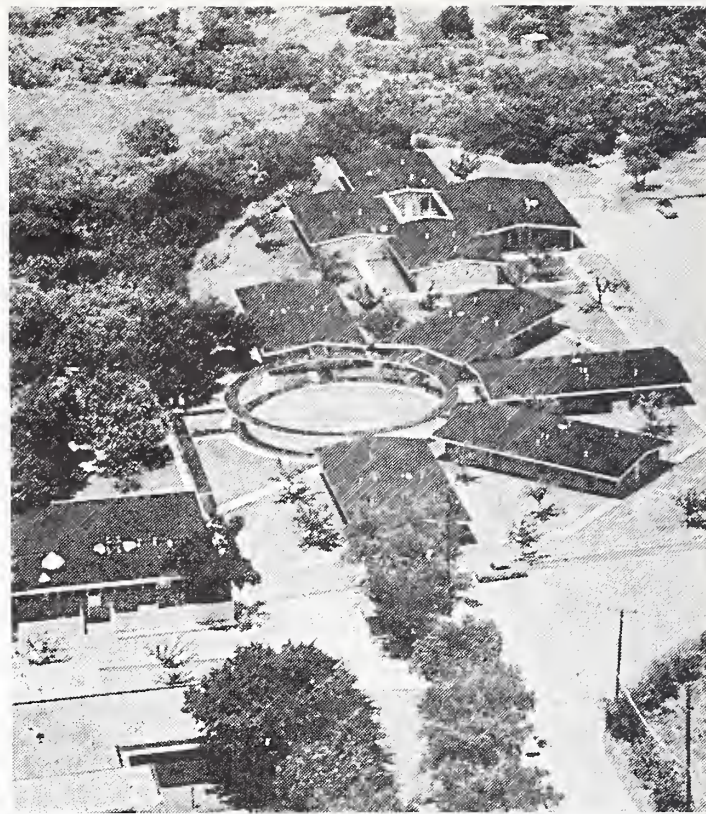
Above, Rex Kenyon, MD, (right), member of AMPAC Board of Directors, is shown congratulating Kent Braden, MD, (left) and Ed L. Calhoon, MD, Chairmen of the Oklahoma Medical Political Action Committee for 1974-75, with an award for second place winner in the National AMPAC campaign.



Seen at the left are Thomas N. Lynn, MD, (right), acting Dean of the University of Oklahoma Health Sciences Center, receiving an AMA-ERF check for \$17,648.38 from Arnold G. Nelson, MD, incoming President of the OSMA.

Pictured right, Howard B. Keith, MD, Shattuck, is shown receiving a plaque of appreciation from Jack L. Richardson, MD, Tulsa, President of the OSMA. Doctor Keith's outstanding service on the Peer Review Committee for seven years was acknowledged by the OSMA House of Delegates.





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Sixteen Resolutions Considered By House of Delegates

During the Annual Meeting of the OSMA House of Delegates, held April 23rd-26th, the House considered 16 separate resolutions. The annual meeting of the house was held in conjunction with Oklahoma Medical Summit, the combined annual meeting of the OSMA, Oklahoma Academy of Family Physicians, and Oklahoma City Clinical Society in Oklahoma City's Lincoln Plaza Hotel.

The Opening Session of the House of Delegates was conducted on Wednesday afternoon, April 23rd, the Reference Committees met on April 24th, and the Closing Session was Friday morning, April 25th.

The sixteen resolutions considered by the House came from various county medical societies and individual members of the association.

Resolutions Nos. 2, 3 and 6 all dealt with proposed amendments to the OSMA Constitution and By-laws and whether or not American Medical Association membership should be mandatory in Oklahoma. A full explanation of what happened on these three resolutions is contained in a separate story in this issue of *The Journal* dealing with the AMA dues.

Resolution No. 1 was introduced by the Oklahoma County Medical Society and dealt with insurance claim forms. This resolution resolved that physicians of Oklahoma be encouraged to use the AMA's Uniform Claim Form for all accident and health insurance reports and that if an insurance company insisted on its own form, an appropriate charge could be made by the physician for his time and inconvenience.

In its report, the Reference Committee noted that no member of the Oklahoma County Medical Society was available to bring to the committee information on the AMA Uniform Claim Form. Lacking this information, the committee felt that it could not recommend passage of the resolution. The house concurred, and the resolution did not pass.

The house next dealt with Resolution No. 12, submitted by the Oklahoma County Medical Society in regard to AMA Publications. The house adopted the following amended resolution No. 12: Resolved, that the Oklahoma State Medical Association urge the American Medical Association to discontinue, immediately,

free distribution of all publications, except for JAMA and items of news or organizational interest, and, be it further

Resolved, that the AMA establish a subscription price that will pay for its other publications, or, if such a subscription price is not feasible, that it discontinue, immediately, the publication of specialty journals, Prism, and all other magazines, leaflets, and brochures not fiscally sound.

All of the above cited resolutions were considered by Reference Committee No. I. Reference Committee No. II considered Resolutions Nos. 7, 8, and 15.

The Reference Committee dealt with Resolutions Nos. 7 and 8 jointly. Both were introduced by the Kingfisher County Medical Society and No. 7 dealt with "release of information to third party carriers" while No. 8 was on "pre-existing illnesses." In its report the committee stated, "Both resolutions . . . deal with insurance companies and the policies they use to underwrite the risks they insure."

Resolution No. 7 expresses concern over the retrospective review of patients' medical records after claims have been filed. Resolution No. 8 addresses itself to the problem of the "pre-existing illness" clause and insurance policies that result in the denial of some claims. Testimony (before the committee) cited the problems of patients who, after paying premiums for years, find that specific illnesses are not covered on the grounds of being "pre-existing." Your Reference Committee expresses concern over the less than honorable practice of some insurance companies, but we recognize that certain information and investigations are necessary to the insurance industry.

The reference committee then recommended that both resolutions be referred to the OSMA's Council on Insurance with instructions that they study these problems and make recommendations to the Board of Trustees. This recommendation was adopted by the House of Delegates.

Resolution No. 15, introduced by the OSMA Medical Center Liaison Committee and the OSMA Legislative Committee, requested that a committee be appointed to study the admissions policy of the OU College of Medicine. The committee pointed out, ". . . it is obvious that a great number of physicians in the state, in addition to our political leaders and the lay

(Continued on Page 177)

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public, do not understand the admissions policies of the OU College of Medicine. We feel that a comprehensive study with accompanying public relations and dissemination of information to the physicians of Oklahoma would be of great benefit to the school."

The resolution called for the creation of a special committee to consist of two physicians from each of Oklahoma's six Congressional Districts and five physicians representing the faculty and staff of the OU College of Medicine. This committee was to convene as often as necessary to study the admissions policy of the College of Medicine and to then file a full report of its findings with the Executive Committee of the Oklahoma Legislative Council at least 30 days prior to convening of the second Session of the 35th Oklahoma Legislature.

The Reference Committee, in its report to the house, noted that it had been informed that a Senate joint resolution had been passed by the Oklahoma Senate that would legislate the composition of the Board of Admissions. The committee had also been advised that the authors of the bill had under consideration amendments that would require membership of the Board of Admissions to represent each of the six Congressional Districts.

Reference Committee No. III considered Resolutions Nos. 4, 5, 9, 10, 11, 13, 14 and 16.

Resolutions Nos. 5, 10 and 13 were considered jointly. The first two were introduced by the Kingfisher County Medical Society, and the Oklahoma County Society introduced No. 13. Each dealt with the new Utilization Review Regulations being promulgated by the Secretary of HEW.

The reference committee drafted a substitute resolution to be adopted in place of the three. A full report on the substitute resolution and the actions that followed its adoption are included in another article in this issue of the OSMA *Journal*.

Resolution No. 4 was introduced by the Tulsa County Medical Society and dealt with support of Emergency Medical Services Systems. It was considered by the reference committee in conjunction with the report of the Emergency Medical Services Committee of the Council on Public Health of the OSMA. This resolution resolved that the OSMA should "support the concept of the comprehensive system of Emergency Medical Services, and that physicians evidence their support by participa-

tion in activities of design and development of Emergency Medical Services Systems; and . . . that physicians support and participate in the training of Emergency Medical Technicians and other allied health personnel in the delivery of such services; and . . . that physicians participate in the assurance of the capability of hospitals to deliver quality emergency care; and . . . that the OSMA urge other health professional organizations to resolve their support for such Emergency Medical Services Systems."

Resolution No. 9 dealt with the "repeal of HEW's Professional Standards Review Organization" and was introduced by the Kingfisher County Medical Society. After consideration by the Reference Committee, the committee noted that it felt this resolution was simply a restatement of the association's current policy.

Resolution No. 9, as adopted, resolved that "HEW's Professional Standards Review Organization law be repealed and that this stand for repeal be adopted by the Oklahoma State Medical Association."

Ray McIntyre, MD, representing the Kingfisher County Medical Society stated that it was not the intention of this resolution to withdraw the House of Delegates permission to the Oklahoma Foundation for Peer Review to apply for a PSRO Planning Grant. He stated the intent of the resolution was simply to reaffirm the association's position that the law should be repealed.

The Comanche-Cotton-Tillman Counties Medical Society introduced Resolution No. 11 dealing with "collective bargaining by the AMA." The resolution called for the AMA to change its structure or constitution and add a division "to allow its members to be represented by an effective collective bargaining agent to deal with all organizations involved in health care . . ."

The reference committee pointed out to the House of Delegates that it had been informed that the AMA had created an Office of Negotiations that was already active. It further stated that until such time as the new offices' functions were clarified and delineated, it did not feel that the OSMA should take any action on the subject of collective bargaining by the AMA. The resolution was not adopted.

Two physicians from Stillwater, William Garnier, MD, and Sidney Williams, MD, intro-

duced Resolution No. 14 on the subject of "eyeglass prescriptions from ophthalmologists." In their resolution they pointed out that the Judicial Council of the American Medical Association requires physicians to furnish to their patients copies of any prescriptions for eyeglasses, drugs, or appliances. They then went on to point out that the peculiarities of Oklahoma law hold ophthalmologists liable for the "full effect" of any eyeglasses furnished in response to a prescription.

After hearing testimony, the reference committee recommended that the section of the Oklahoma Statute cited in the resolution was at fault and should be changed. However, it felt that the Judicial Council's opinion should be maintained in force.

Doctor Garnier personally appeared before the House of Delegates and asked that the Reference Committee recommendation be overturned and that his resolution be adopted.

Following some limited debate, the House of Delegates approved a substitute motion to the effect that the Judicial Council's opinion in regard to the prescription for glasses be waived until such time as the Oklahoma law is changed.

Resolution No. 16 was introduced by Kent Braden, MD, and dealt with many aspects of the "physician-patient relationship."

In its report to the House of Delegates the Reference Committee stated, "Mr. Speaker, your committee considered this resolution very carefully. While the committee admired the philosophy outlined in this resolution, the resolves it contains are so far reaching and encompass so many facets of the social, economic, and political aspects of the practice of medicine as to make it untenable in this form. Many of the resolves are being handled specifically by the reports of the association's various councils, committees, and other resolutions.

"Your committee wishes to specifically commend Kent Braden, MD, for so eloquently outlining the philosophy that we would all like to espouse. However, an attempt to encompass it all in one omnibus resolution simply is unworkable."

The Chairman of the Reference Committee then moved that Resolution 16 not be adopted. This motion was accepted by the House of Delegates. ☐

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House Votes to Retain Mandatory AMA Membership

The OSMA House of Delegates, meeting in regular session on April 25th, voted to retain that section of the OSMA By-laws that require members of the state association to also belong to the American Medical Association.

The house rejected several resolutions calling for AMA membership to be voluntary. One reference committee of the house considered a number of resolutions on the subject when it met on Thursday, April 24th. Following the presentation of numerous oral arguments for and against voluntary AMA membership, the reference committee proposed that the three resolutions on the subject be considered as a single item by the delegates. The reference committee was unable to reach a unanimous decision as to what action should be recommended to the delegates.

Following lengthy discussion on the floor of the house, it was moved by a delegate from Washington County that the mandatory AMA membership be retained. The motion was seconded and passed by the delegates.

The action of the House of Delegates leaves the by-laws of the state medical association as they are currently written: *ie*, in order to be a member of the Oklahoma State Medical Association, a physician must also be a member of his local county medical society and the American Medical Association. ☐

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OSMA House Votes Dues Increase

A \$30 dues increase, to bring OSMA dues to \$150 annually, was voted by the medical association's House of Delegates when it met on Friday, April 25th, during Oklahoma Medical Summit.

The Annual Report of the OSMA's Board of Trustees to the House of Delegates illustrated the need for a dues increase by showing the ever-widening areas of activity of the association. The trustees observed to the delegates that the association cannot operate at its past level without experiencing a deficit. The board then took the position that the OSMA could not be permitted to deteriorate in any fashion, and requested that the House of Delegates adopt a dues increase for 1976.

The reference committee that considered the reports of the Board of Trustees, Supplemental Board of Trustees Report, and Secretary-Treasurer Report, recommended that the dues be increased by \$30. This amount would produce approximately \$25,000 in new income for

the next fiscal year and would generate as much as \$60,000 for the following fiscal year. The fiscal year of the association runs from June 1st through May 31st of the following calendar year.

The reference committee cited to the House of Delegates that numerous major issues were currently confronting the association, "such as the matter of non-participation in federalized Utilization Review Regulations. A strong stance against these regulations will present a major public relations problem to the association which cannot be sustained by any reasonable dues increase."

The Report of the Reference Committee then went on to state, "your committee, therefore, observes to the House of Delegates that major confrontations against onerous federal regulations will undoubtedly require a special assessment in order to develop a successful response to punitive federal actions which may be taken against the profession."

The new dues increase will become effective January 1st, 1976. The association operates on a fiscal year, but collects its dues on a calendar year. The dues increase will be included in the dues statements to be sent out in December of this year. □



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Death

ROBERT L. LOY, JR., MD
1914-1975

Robert L. Loy, Jr., MD, Oklahoma City general practitioner, died April 9th, 1975. Born in El Reno, Doctor Loy lived most of his life in Oklahoma City. In 1947, he was graduated from the University of Oklahoma College of Medicine, where later he became an Instructor in Obstetrics.

Doctor Loy served with the US Army during World War II and was a member of the county, state and national medical associations. □

Arkansas-Oklahoma Cancer Forum Scheduled For September

Fort Smith, Arkansas, has again been selected as the site of the Seventh Annual Arkansas-Oklahoma Cancer Forum. Dates for the one and a half-day meeting will be September 25th and 26th, 1975.

According to Guy Robbins, MD, Head of the Breast Service, Memorial Hospital, New York City, an outstanding program is being formulated. Speakers from Memorial Hospital and the Sloan Kettering Institute will highlight the presentations. A wide variety of subjects, including practical topics and recent innovations, will fill the program.

The Sheraton Inn in Fort Smith will be headquarters for the forum. Further details will be announced later. □

Summit Photo Contest Winners Announced

Six Oklahoma physicians were selected as winners in the Oklahoma Medical Summit Photography Contest for physicians and their spouses.

The two judges, David Fitzgerald, a commercial photographer in Oklahoma City, and Raymond Riggs, an international amateur salon exhibitor, unanimously selected Doctor Harold Sleeper's photograph of a hummingbird as the "Best Of Show." Both photographers pointed out the technical difficulties involved in making such a photograph.

First place in the color competition was won by Fred Switzer, MD, of McAlester for his

photograph of a mountain pass. Second place in the color competitions went to Marcel Binstock, MD, of Tulsa for his photograph of "Mountain Meadow."

In the black and white competition, Ken Whittington, MD, of Oklahoma City won first place with his photograph of a boy with a pumpkin. Second place went to Doctor Richard Dawson of Oklahoma City for his photograph of a girl in a car window.

Both judges insisted that an honorable mention be given to the two color photographs of an oil well fire by Doctor Bill Leebron of Elk City. Both judges noted that from the standpoint of interest, there probably were not two more popular photographs in the display. □

L. H. Becker, MD, To Be Honored

The residents of Blackwell, Oklahoma, will honor Doctor L. H. Becker at an open house on June 1st, 1975. The event will be held in the V.F.W. Hall in Blackwell from two to five Sunday afternoon. All medical associates and friends of Doctor Becker's are urged to attend.

Doctor Becker has been in general practice in Blackwell since 1927. □

Braden Seeks New OMPAC Members

Kent Braden, MD, Chairman of the Oklahoma Medical Political Action Committee is seeking new members for OMPAC. In a letter to all OSMA members, he said, "The bitter truth is simply this, the 1974 elections resulted in the worst losses for the conservatives and moderates since 1964, the Goldwater year."

The Chairman of the Political Action Committee went on to state, "It was a loss, but not a total defeat. It was a loss that can be countered in 1976 if we begin working now!"

While asking all Oklahoma physicians to join OMPAC as either regular members with dues of \$20 a year or sustaining members with dues of \$100 a year, he went on to point out, "It is known that the chiropractors in some states, including Oklahoma, have collected as much as \$500 per member to support candidates espousing their philosophy, we can afford to do no less."

OMPAC memberships or inquiries may be directed to P.O. Box 18759, Oklahoma City, Oklahoma, 73118. □

Book Review

HAIR TRANSPLANT SURGERY — by O'tar T. Norwood, MD, Assistant Clinical Professor of Dermatology University of Oklahoma Medical School, Oklahoma City, Oklahoma. First Edition, 108pp., Springfield, Illinois. Charles C. Thomas-Publisher, 1973

This text of hair transplant surgery is divided into ten chapters. The first chapter consists of a classification of male pattern baldness. This classification should be very helpful to the physician in choosing his candidates for hair transplant surgery.

Chapters 2 and 3 deal with the initial interview of the patient and the physician's criteria in selecting candidates for the procedure. The hand-out sheets for the patient should answer many of the questions the patient may ask. I think a more complete medical history and physical examination is warranted than that which is mentioned in the book. In particular, I think a medical history of diabetes, psychological disorders and other general diseases should be documented before beginning the procedure.

Chapters 4, 5 and 6 deal with organization and planning, the surgical procedure, and

complications. These chapters serve as an excellent guideline of the step-by-step technique of hair transplantation.

Chapter 7 discusses the use of hair transplants in alopecia other than male pattern baldness.

The size of punches used for the surgery is thoroughly covered with a special chapter (8) devoted to the use of the 5 millimeter punch.

Chapter 9, polling many of the physicians doing hair transplants, should alert the reader to possible complications which he may encounter in doing the surgery.

The final chapter deals with the current status of hair-bearing homografts and organ transplantation.

The black and white photography throughout the text is of good quality but the color photograph section is of poor quality and, in my opinion, should be replaced by black and white photographs or left out altogether.

Doctor Norwood's book is a thorough text on the subject of hair transplantation and should be in the library of any physician interested in hair transplantation surgery. He deserves congratulations for compiling information on a very timely surgical procedure. *Julian W. Swann, MD, Assistant Professor of Medicine, Dermatology Division, Emory University School of Medicine, Atlanta, Georgia.* □

SEVENTH ANNUAL ARKANSAS-OKLAHOMA CANCER FORUM

September 25th-26th, 1975

Fort Smith, Arkansas

This one and one-half day meeting will be held at the Sheraton Inn in Fort Smith, September 25th-26th, 1975.

Guest speakers from Memorial Hospital, New York City and the Sloan Kettering Institute will highlight the program.

Further details to be announced later.



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A public relations campaign to explain the OSMA's position regarding Utilization Review is being prepared by a Tulsa Consulting Firm. The campaign, authorized by the House of Delegates, will be based on the adverse effect the new Utilization Review Regulations have on patient care, *ie*, rationing of patient care and the possible closure of small hospitals. The American Medical Association has pledged to furnish the state with technical assistance in the preparation of the campaign.

The Oklahoma Medical Political Action Committee took second place in national competition for number of sustaining members. It is significant that a small state like Oklahoma can compete with such states as California, Texas, and New York in competition for the number of sustaining members. The award was presented publicly during Oklahoma Medical Summit '75 by Rex Kenyon, MD, a member of the national AMPAC Board. It went to Ed Calhoon, MD, OMPAC Chairman for last year and Kent Braden, MD, this year's chairman.

The American Medical Association's recently introduced national health insurance plan, HR6222, is being described as "the only substantially new approach . . . presented so far in the 94th Congress." The plan is called a "Comprehensive Health Care Insurance Act." It deals on the present system of employer-employee group health insurance plans, mandating each employer to provide comprehensive and catastrophic benefit coverage with the employer picking up at least 65 percent of the cost. Medicare beneficiaries could purchase supplemental insurance to bring their benefits up to par with those offered elsewhere.

Congress has been told that federal intervention in the professional liability crisis could "create a worse situation and in some cases result in even higher liability costs." AMA President Malcolm C. Todd, MD, told the Senate Health Subcommittee headed by Senator Kennedy that "it is far wiser for states to enact varied innovative legislative responses to the problem than to have an untested and unproved scheme enacted on a nationwide basis by the

federal government, particularly where such proposals contain elaborate provisions for federal government regulations of the practice of medicine." Todd's remarks were echoed by Richard E. Palmer, MD, Chairman of the AMA Board of Trustees. He went on to say, "The complexity of the problem, and its varied causes convince us, however, there is no single solution, be it arbitration, 'no fault', or anything else."

Governor David Boren is actively involved in a "selling" campaign to encourage Oklahoma-educated physicians to stay in the state to practice or return to the state if they sought postgraduate education elsewhere. He has written every OU College of Medicine graduate for the past five years who is out of state urging them to return. The Governor's efforts are being coordinated by the Oklahoma Council for Health Careers, Inc., a private non-profit corporation that was originally started by the Oklahoma State Medical Association. Its purpose is to recruit young people into health careers.

PSRO Law Amendments, proposed by the AMA, were introduced earlier this month in the United States Congress. The 19 Amendments to the PSRO Law would clarify the purpose and function of criteria of care, increase safeguards to confidentiality, eliminate harsh penalties, repeal overlapping Utilization Review Programs recently advanced under other sections of the Social Security Act, and extends utilization review and medical audit programs to federal medical installations.

Number of Health Maintenance Organizations, originally touted as "the answer" to the health care delivery problem, has begun to decline. According to the Washington report on Medicine and Health, "the Minneapolis Think Tank that put Health Maintenance Organizations into the Health lexicon says a quarterly survey shows that 'for the first time, HMO numbers are declining slightly.' The total number of HMO's in the country stood at 181 the first of this month (April), down 2 from January. . . ." On another front, one of the organizations that was a prime mover behind the HMO's, the AFL-CIO, is now criticizing HEW for its implementation of the HMO Regulations. The huge labor union now finds that the regulations would weaken its power to bargain for health care benefits. □

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LETTER FROM THE EDITOR: I

To the Chairperson
Pre-admission Utilization
Review Committee
Community Hospital, USA

Dear Person:

It has come to my attention that your committee, acting in concert, has intervened in the course of therapy which I have advised for my patient, Mr. John Public, and, as a consequence, he has been refused admission to the hospital.

The purpose of this letter is to advise you and the members of your committee that, in my personal and professional opinion, you have assumed full responsibility for Mr. Public's future health care.

Prior to your unsolicited evaluation of his condition and medical needs, Mr. Public had been under my care and observation for a period of twelve years. During that time, he enjoyed relatively good health, was a cooperative and well-motivated patient, and conscientiously followed my advice in matters pertaining to his health. In seeking admission to the hospital he was, quite obviously, acting upon my advice. Had I believed that any course of action other than hospitalization would have been more or equally beneficial I would not have advised his admission.

As you and your committee members are professionally unknown to me, I know nothing of your credentials. Certainly, I would never

advise any of my patients to follow the recommendations of an anonymous interloper whose qualifications, character and experience are, at best, unverified.

I understand that you and your committee members operate within a framework of laws which provide you with certain immunities which I do not share in my relationship with Mr. Public. Notwithstanding this fact, I have notified my patient, in writing, that because of your actions, I can no longer be responsible for his care. I prescribed hospitalization for him and hospitalization is the only recommendation I have. Since you and your committee, functioning as alien, uninvited consultants, directed and paid by fiscal interests, have intervened and made alternative recommendations imperative, I am assuming you know of and can recommend some alternatives which are unacceptable to me.

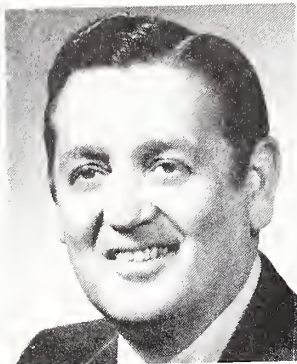
Therefore, I have suggested to Mr. Public that he contact you and follow your advice about his future medical care. I have also explained to him that, even though we are not acquainted, you must be a competent, dedicated and exceptionally talented person because of your extremely powerful and responsible position.

I do hope you find this information helpful in your subsequent care and management of Mr. Public's case. He is a fine person and I am sure you will enjoy caring for him.

Very cordially yours,
Mark R. Johnson, MD

MRJ

Since I took office as President of the Oklahoma State Medical Association, I have been busy putting out one fire after another. It has been much like the private practice of medicine in that I have encountered one emergency after another. Each problem needs to be taken care of in its own special manner.



The smoke had hardly cleared from the House of Delegates Assembly Hall when we began work carrying out the orders that had been handed down by the delegates. With passage of the resolution of non-participation in utilization review as written in Federal Registry of November 29, 1974, by Secretary Caspar Weinberger, it became necessary to attack that fire first.

A strong Council on Public Policy was appointed with Doctor Joe Crosthwait as its chairman. Some members of this council have met several times weekly since their appointment. Doctor Crosthwait, Doctor Braden, Mr. Ed Kelsay, Mr. David Bickham and I made a flying trip to Washington, D.C. to meet with Senator Henry Bellmon, Jay Constantine and a dozen bureaucrats from the Department of Health, Education and Welfare and related organizations. We felt that our meeting was a success. At the present time, the Public Policy Council is attempting to write a new, superior and acceptable Utilization Review plan. By acceptable, I mean acceptable to the physicians of Oklahoma and acceptable to Secretary Weinberger as a substitute U.R. plan for Oklahoma. It will be necessary to carry out further negotiations in Washington with the high officials of HEW, namely Secretary Weinberger, when the superior Oklahoma plan is completed.

The Council on Public Policy is also very busy with plans for a public relations campaign to educate the citizens of Oklahoma with respect to the dangers of the federal utilization review plan as it is written today.

SOME OF THE DANGERS ARE:

1. The hospital benefits promised by Congress to the elderly and the poor would be sharply reduced. Then I would say we would have a rationing of care to the poor and the elderly.
2. The regulations as currently written by Secretary Weinberger violate the rights of all Medicare and Medicaid patients to receive whatever treatment their physician feels is best.
3. The regulations would invade the right of privacy, concerning information given to their physician in complete confidence.
4. The regulations as written could force as many as 50 small Oklahoma hospitals to close.
5. HEW claims the regulations will improve medical care. What it really amounts to, is a "cost control" program, at the expense of good medical care for the poor and the elderly.
6. Rather than save money for our government, it has been predicted that the administrative costs will increase far beyond any savings.
7. Implementation of these regulations would take even more of the physicians' time, therefore there would be even less time to spend with patients.

I would be remiss in writing this President's Message if I did not make some remarks concerning the Oklahoma Medical Summit, 1975. I thought it was the greatest medical meeting ever assembled in Oklahoma. More than one-third of the physicians of Oklahoma were in attendance. Next year we must strive for an even bigger and better meeting. Overall, I thought Summit '75 was a tremendous success and I want to thank the Steering Committee, the other committees and all who made it a success. I want to thank the entire executive staff as well as the secretarial staff for their contributions, for without them it would have been an impossible task.

Arnold G. Nelson, D.D.

The Influence of Robert Burton and Clifford Whittingham Beers on the Development of Psychiatry

STEVEN C. HARDY
VIRGINIA R. ALLEN, PhD

The United States has pioneered in the field of mental hygiene in the twentieth century. Two laymen, one in the seventeenth century and one in the early twentieth century, made significant contributions to its development.

William Osler regarded the modern period as the age of preventive medicine.¹ Discoveries in bacteriology, hygiene, biochemistry, and nutrition led to significant advances in preventive medicine and the prolongation of life. The United States pioneered in a special field of preventive medicine — the mass application of mental hygiene — with the founding of a national hygiene movement in 1909.

Erwin Ackerknecht, historian of medicine, viewed the resurgence of psychosomatic medicine in the following light:

What appears to have happened is that in the latter part of the nineteenth century and the first half of the twentieth century the old insights were lost in the

shuffle of fascinating objective discoveries with the attendant overmechanization and overspecialization. Doctors became so laboratory-minded, so scientific, and so impersonal, that they forgot, or felt entitled to ignore, the patient as a person. It is a queer reflection on the present age that one of the basic medical functions of all times now had to be re-introduced — as a new specialty.²

Two men, Robert Burton and Clifford Beers, both non-physicians, made significant contributions to the humanitarian application of preventive medicine to mental hygiene. Although widely separated in time, their work had many similarities. Out of their individual life experiences each brought forth an influential literary work. This literature reflected their need to focus upon problems of the mind, and those who treat patients with mental dysfunctions.

Robert Burton, the son of Dorothy Burton, a surgeon, and Ralph Burton, Esq., was born on February 8, 1577 at Lindley, Leicestershire, England. His schooling was at Sutton Coldfield, Warwickshire, and at Nuneaton Grammar School. The fourth of nine children, he showed the signs of a depressive character early in life, and felt he had been denied affection.³ In 1593 Burton entered Brasenose College, Oxford as a "commoner." In 1599 he

was elected student of Christ Church [College], where he continued his scholarly activities throughout his life. He received the degree of Bachelor of Divinity in 1614. A vicarage in Oxford and a rectory in a country parish provided his living.⁴

Burton was by profession a divine, but by inclination a physician. He devoted his life to the study of mental aberrations and was concerned with no other branch of medicine, unless it was related to this central interest.⁵ Eighteen times during his forty-seven years at Oxford he published Latin verses in various college and university publications. A satirical play, *Philosophaster*, was written in 1606 and was performed at Christ Church in 1617. In 1621 he published his most important work, *The Anatomy of Melancholy*. This brought recognition and wealth, but did not dispel his disappointment with life, which resulted from excessive expectation rather than meager accomplishment.⁶ He died on January 25, 1640, almost exactly at the time he had predicted. The epitaph, inscribed in Latin on his tomb at Christ Church, summarizes his life:

Known to few, unknown to fewer,
here lies
Democritus Junior,
to whom melancholy gave both life and death.

Burton's *Anatomy* was written in light of contemporary medical science which had been handed down from the great physicians of the Greek culture — Hippocrates and Galen. The body was thought to contain four humors: blood, phlegm, choler (yellow bile), and melancholy (black bile). It was held that a proper balance of the quantities of these humors would result in good health, and their proportions determined the complexion (temperament). When blood was uppermost a man was sanguine; when phlegm was in excess he was phlegmatic; when he had too much choler he was bilious; and extra melancholy made him atrabilious, or, if very disproportionate, insane.⁷ *The Anatomy of Melancholy* begins with these words:

The Anatomy of Melancholy, what it is. With all the Kindes, Causes, Symptomes, Prognostickes, and severall cures of it. In Three Maine Partitions with their severall Sections, Members, and Subsections. Philosophically, Medicinally,

historically, opened and cut up. By Democritus Iunior.⁸

Interpreters of Burton have found three Robert Burtons. To early scholars such as Thomas Fuller, Burton was the author of an encyclopedia, "a miscellany of familiar and unfamiliar quotations, a source of rich material for plagiarists."⁹ Charles Lamb and other interpreters through the nineteenth century saw Burton as a "fantastic old man," who was a quaint literary stylist, and curious museum piece.¹⁰ They seldom viewed him dispassionately, but usually with either adoration or scorn. Twentieth century recognition of Burton's serious intention was due primarily to William Osler, who was the first critic to comprehend the real nature of Burton's work. Three hundred years after it was written, Osler spoke of *The Anatomy* as the greatest medical treatise ever written by a layman.¹¹ Osler's interpretation bears a marked resemblance to Burton's self-portrait — the anatomist of melancholy.

Burton's intent was to anatomize melancholy through all of its facets so that it could be avoided. He knew of no better way to spend his time than in prescribing the means of preventing and curing the seemingly universal malady of melancholy. Its universality was due to a great extent to the economic crisis that Jacobean England was experiencing. *The Anatomy of Robert Burton's England*, by William Mueller, is a sociological study of the economic, political, social, and religious blight in which Burton lived. A psychological analysis in Bergen Evans' *The Psychiatry of Robert Burton* reveals the perceptiveness of Burton's theories of psychiatry in the light of modern psychological thought.

The compassion which underlies *The Anatomy* was a result of the suffering endured by Burton himself. It influenced his perception of the need for the humane care which is now regarded as indispensable for successful treatment. Phillipe Pinel is generally credited with being the first physician to appreciate the necessity for kindness and sympathy in the treatment of the insane and to institute rational methods of treatment. In 1795, Pinel, at Salpêtrière, removed the shackles from the mentally ill and prescribed hospital care for them. The acknowledgement of Pinel's methods as a revolutionary milestone in the course of psychiatry illustrates how completely Burton's plea, made a hundred and seventy years earlier, had been disregarded.

Burton understood quite clearly that mental disturbances can be treated. He insisted that the patient's total situation must be taken into consideration — his emotional state and attitudes, his intimate personal relationships, his occupation and other activities, and his social environment. In this insistence, he anticipated the most modern conceptions. Only in the past century have techniques for systematic and coordinated medical, psychological, and social studies of the neurotic or psychotic individual been incorporated into the procedures of psychiatric clinics.

The first coordinated medical effort at psychiatric treatment occurred at the leading medical center in the United States, Johns Hopkins University and Hospital. There, William Osler introduced precise laboratory methods and exact science into the field of clinical medicine. Not only was Osler a leading clinician, he was a "born humanist."¹² His humanism in clinical medicine was influential in the environment of Johns Hopkins, and his intense interest in Robert Burton probably induced many of his students and colleagues to read *The Anatomy*. This exposure predisposed the favorable reception of the well-penned story of Clifford Whittingham Beers. Beers had borne the ignorance, callousness, and irresponsibility commonly found in insane asylums of the late nineteenth century.

Clifford Beers was the fifth of six sons in a modest and happy family in New Haven, Connecticut. He was a Yale College graduate with an interest in business. In 1894, an elder brother was stricken by epileptic convulsions. Although the illness was later diagnosed as a brain tumor, Beers had become obsessed with the fear that he also would develop epilepsy. His pent-up fears overwhelmed him into a state of mental collapse and drove him to attempt suicide in 1900. His desperate leap rid him of his fear of epilepsy, but he began three years of unreason, terror, ecstasy and suffering which he vividly recounts in his book.¹³ Out of

his experiences, he gleaned the insight and introspection to express his suffering through writing. *A Mind That Found Itself* aided his efforts to reform the fortresses of apathy and abuse, which persisted in spite of the efforts of Dorothea Dix and other reformers of the mid-1900's. Beers declared that the most important purpose of his book was to wage an educative war against the prevailing ignorance regarding insanity, and to promote the role of mental hygiene in the curtailment of mental dysfunction.

Beers began writing *A Mind That Found Itself* in 1904, after being encouraged by Joseph K. Choate, who told him that busy men might read a book in their lesiure moments when they would not take the time to listen to his plans for reform. The manuscript at once won the interest and active aid of William James, and a year later the support of Adolf Meyer and other outstanding leaders in psychiatry. Doctor Meyer gave the name "mental hygiene" to the movement whose planning and organization consumed all of Beers' energy.¹⁴ The book also facilitated Beers' founding of the Connecticut Society for Mental Hygiene (1908), the National Committee for Mental Hygiene (1909), and the American Foundation for Mental Hygiene (1928).

The Anatomy of Melancholy and *A Mind That Found Itself* greatly influenced the environment of Johns Hopkins. In Osler's farewell address at Johns Hopkins (1905), he specifically mentioned the urgent need for a psychiatry department. A few years later Doctor William H. Welch gave Henry Phipps a copy of Beers' book. The result was the funding of the Henry Phipps Psychiatric Unit, which opened in 1913.¹⁵

Many parallel and contrasting facets of the two men who produced these literary masterpieces are apparent. Their lives were dominated by their humanitarian interest in the problems which plague men's minds. Each had personal psychiatric disorders. Although Burton's depression was not as severe, it was prolonged. Beers' acute mental illness was relatively short-lived, but was accompanied by attempted suicide and followed by a period of severe manic-depression. Each plunged into a career, Burton because of his scholarly nature, and Beers because of his fear of a hereditary disease. Burton recognized the humanitarian needs of those suffering from mental disease; Beers promoted fund-raising for the implemen-

Steven Hardy is a student at the University of Oklahoma and will receive a BS in Zoology and a BA in psychology in May, 1975. Doctor Allen is an Instructor in History of Medicine at the University of Oklahoma Health Sciences Center and an Adjunct Instructor in History at the University of Oklahoma. Mr. Hardy prepared a draft of this paper during a course in the History of Biomedical Sciences.

tation of research and the upgrading of facilities and services available to the mentally ill. Burton gave his life to melancholizing, and Beers gave his to mental hygiene.

What gave Burton's work its psychopathological importance was his ability to look objectively into the mentality of the melancholic. His insight was a forerunner of the development of a comprehensive pathology of depression, with self-destructive hostility as its core. The therapeutic value of the modern concept of transference was recognized by Burton when he advised: "A friend's counsel is a charm, like mandrake wine, it allayeth our cares. . . ." ¹⁶

The preface to the twenty-ninth printing in 1944 of *A Mind That Found Itself* points out the continuing need for concerted effort in mental hygiene:

"We face a troubled world, its unhappy difficulties due in great, perhaps greatest part, to the mental, physical and moral maladjustments of its peoples . . . But mental hygiene has not as yet been far enough advanced to play its essential part. When it has been, and the coordinated efforts of those who heal the mind, of those who heal the body, and of those who heal the soul are brought to bear upon our world problems, shall we not see the beginnings of a brighter day—the rise of a finer and more stable civilization?" ¹⁷

No better tribute can be made to Burton and

Beers than to nourish, vitalize, and carry forward their work.

ACKNOWLEDGEMENTS

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Requests for the book should be directed to the Oklahoma State Medical Association, 601 Northwest Expressway, Oklahoma City, Oklahoma 73118.

There is no charge for this booklet.

GONORRHEA

Recommended Treatment Schedules—1974

Physicians are cautioned to use no less than the recommended dosages of antibiotics.

UNCOMPLICATED GONOCOCCAL INFECTIONS IN MEN AND WOMEN

Drug Regimen of Choice:

Aqueous procaine penicillin G (APPG), 4.8 million units intramuscularly, divided into at least two doses and injected at different sites at one visit, together with one gram of probenecid, by mouth, just before the injections.

Alternative Regimens:

A. Patients in whom oral therapy is preferred: Ampicillin, 3.5 gm, by mouth, together with one gram probenecid by mouth, administered at the same time. There is evidence that this regimen may be slightly less effective than the recommended APPG regimen.

B. Patients who are allergic to the penicillins (penicillin G, ampicillin) or probenecid*:

1. Tetracycline hydrochloride, 1.5 gm initially by mouth, followed by 0.5 gm by mouth four times per day for 4 days (total dosage, 9.5 gm). Other tetracyclines are not more effective than tetracycline hydrochloride. All tetra-

cyclines are ineffective as single-dose therapy.

2. Spectinomycin hydrochloride, 2.0 gm intramuscularly, in one injection.

Treatment of Sexual Partners:

Men and women with known recent exposure to gonorrhea should receive the same treatment as individuals known to have gonorrhea. Male sex partners of persons with gonococcal infection must be examined and treated because of the high prevalence of nonsymptomatic urethral gonococcal infection in such men.

Followup:

Followup urethral and other appropriate cultures should be obtained from men, and cervical, anal and other appropriate cultures should be obtained from women, 7 to 14 days after completion of treatment.

Treatment Failures:

Most recurrent infection after treatment with the recommended schedules is due to reinfection. True treatment failure after therapy with penicillin, ampicillin or tetracycline should be treated with 2.0 gm of spectinomycin intramuscularly.

Postgonococcal Urethritis:

Tetracycline, 0.5 gm, four times daily by mouth, for at least 7 days.

*Allergy to penicillin, ampicillin, probenecid, or previous anaphylactic reaction.

Department of Health, Education and Welfare, Public Health Service, Center for Disease Control, Atlanta, Georgia 30333.

Gonorrhea

Pharyngeal Infection:

Pharyngeal gonococcal infections may be more difficult to treat than anogenital gonorrhea. Post-treatment cultures are essential followup for pharyngeal infection. The schedules of ampicillin and spectinomycin recommended for anogenital gonorrhea are ineffective in pharyngeal gonorrhea. Patients with pharyngeal gonorrhea whose infection is not eradicated after treatment with 4.8 million units of APPG plus one gram of probenecid, may be treated with 9.5 gm of tetracycline in the dosage schedule outlined above (Alternative Regimens).

Syphilis:

All patients with gonorrhea should have a serologic test for syphilis at the time of diagnosis. Seronegative patients without clinical signs of syphilis, who are receiving the recommended parenteral penicillin schedule, need not have followup serologic tests for syphilis. Patients treated with ampicillin, spectinomycin, or tetracycline should have a followup serologic test for syphilis after 3 months to detect untreated syphilis.

Patients with gonorrhea who also have syphilis should be given additional treatment appropriate to the stage of syphilis.

Not Recommended:

Although long-acting forms of penicillin (such as benzathine penicillin G) are effective in syphilotherapy, they have *NO* place in the treatment of gonorrhea. Oral penicillin preparations such as penicillin V are not recommended for the treatment of gonococcal infection.

TREATMENT OF UNCOMPLICATED GONORRHEA IN PREGNANT PATIENTS

A. For women who are not allergic to penicillin: Use the regimens of aqueous procaine penicillin G plus probenecid, or use ampicillin plus probenecid, as defined above.

B. Pregnant patients who are allergic to penicillins (there are several possible alterna-

tive regimens, each of which has potential disadvantages):

1. Erythromycin, 1.5 gm orally, followed by 0.5 gm four times a day for 4 days, for a total of 9.5 gm. This regimen is safe for mother and fetus, but efficacy has not been established. Erythromycin estolate should not be used in patients with underlying liver disease.

2. Cefazolin, 2 gm intramuscularly, with 1.0 gm of probenecid. Because of the possibility of cross-allergenicity between penicillins and cephalosporins, this regimen should not be used in a patient with a history of penicillin anaphylaxis.

3. Spectinomycin, 2 gm intramuscularly. This is an effective dose, but safety for the fetus has not been established.

Contraindicated:

Tetracycline should not be used for uncomplicated gonococcal infection in pregnancy because of potential toxic effects for mother and fetus.

ACUTE SALPINGITIS (PELVIC INFLAMMATORY DISEASE)

The diagnosis of acute salpingitis should be considered in women with acute lower abdominal pain and adnexal tenderness on pelvic examination. Since there are no completely reliable clinical criteria on which to distinguish gonococcal from nongonococcal salpingitis, endocervical cultures for *N. gonorrhoeae* are essential in such patients. Therapy, however, should be initiated immediately, without waiting for the results of the cultures.

A. *Hospitalization:* Hospitalization should be strongly considered for women with suspected salpingitis in these situations:

1. Uncertain diagnosis, where surgical emergencies must be excluded.
2. Suspicion of pelvic abscess.
3. Pregnant patients with salpingitis.
4. Inability of the patient to follow an outpatient regimen of oral medication, especially because of nausea and vomiting.
5. Failure to respond to outpatient therapy.

B. *Antimicrobial Agents:* Controlled studies of the treatment of acute salpingitis are not available. Initial management must *AT LEAST* be adequate for gonococcal salpingitis. These regimens are known to be adequate for the treatment of gonococcal salpingitis:

1. Outpatients:

a. 1.5 gm tetracycline hydrochloride, given as a single oral loading dose, followed by 500 mg, taken orally, four times daily for 10 days.

b. Aqueous procaine penicillin G (APPG), 4.8 million units intramuscularly, divided into at least two doses and injected at different sites at one visit, *OR* 3.5 gm of oral ampicillin. One gram of oral probenecid is given along with either penicillin or ampicillin, and both are followed by 500 mg of ampicillin, taken orally, four times daily for 10 days.

2. Hospitalized patients:

a. Aqueous crystalline penicillin G, 20 million units, given intravenously each day until clear-cut improvement occurs, followed by 500 mg of ampicillin, taken orally, four times daily, to complete 10 days of therapy. The need for additional or alternative antibiotics for the treatment of nongonococcal salpingitis requires further study. Since it is impossible to distinguish gonococcal from nongonococcal salpingitis clinically, many physicians also use an aminoglycoside in addition to penicillin and/or antibiotics which are effective against *Bacteroides fragilis* as initial therapy.

b. Tetracycline hydrochloride, 500 mg, given intravenously four times daily until improvement occurs, followed by 500 mg taken orally four times daily, to complete 10 days of therapy. This regimen should not be used for pregnant women or for patients with renal failure.

3. Failure to improve on the recommended regimens does not necessarily indicate the need for stepwise additional antibiotics, but requires reassessment of the possibility of other diagnoses and of the specific microbial etiology.

C. The effect of the removal of an intrauterine device on the response of acute salpingitis to antimicrobial therapy and on the risk of recurrent salpingitis requires further study.

D. *Adequate treatment of women with acute gonococcal salpingitis must include examination and appropriate treatment of their male sex partners because of the high prevalence of non-symptomatic urethral gonococcal infection in such men. Failure to treat male sex partners is a major cause of recurrent gonococcal salpingitis.*

E. Followup of patients with acute salpingitis is essential. All patients should receive re-

peat pelvic examinations and cultures for *N. gonorrhoeae* after treatment.

DISSEMINATED GONOCOCCAL INFECTION

A. Equally effective treatment schedules in the arthritis-dermatitis syndrome include:

1. Aqueous crystalline penicillin G, 10 million units intravenously per day for 3 days, or until there is significant clinical improvement. This may be followed with ampicillin, 500 mg four times a day orally, to complete 7 days of antibiotic treatment.

2. Ampicillin, 3.5 gm orally, plus probenecid, 1.0 gm, followed by ampicillin, 500 mg four times per day orally, for at least 7 days.

B. In penicillin and/or probenecid allergic patients:

1. Tetracycline, 1.5 gm orally, followed by 500 mg four times a day orally, for at least 7 days. Tetracycline should not be used for complicated gonococcal infection in pregnancy because of potential toxic effects for mother and fetus.

2. Erythromycin, 0.5 gm intravenously every 6 hours, for at least 3 days.

C. Additional measures:

1. Hospitalization is indicated in patients who are unreliable, have uncertain diagnosis, or have purulent joint effusions or other complications.

. Immobilization of the affected joint(s) appears helpful. Repeated aspirations and saline irrigations appear beneficial, but controlled studies of these procedures have not been performed. Open drainage of joints other than the hip is now generally discouraged in patients with gonococcal arthritis.

3. Intra-articular administration of penicillin is unnecessary, since penicillin levels in the synovial fluid of inflamed joints approximate serum levels; furthermore, intra-articular injection per se may produce a toxic synovitis.

D. Meningitis and endocarditis due to the gonococcus require high-dose intravenous penicillin therapy (at least 10 million units per day) for longer periods: usually at least 10 days for meningitis and 3-4 weeks for endocarditis.

GONOCOCCAL INFECTION IN PEDIATRIC PATIENTS

Pediatric patients encompass those from birth to adolescence. When a child is post-

Gonorrhea

pubertal and/or weighs over 100 pounds, he or she should be treated with dosage regimens as defined above for adults.

WITH GONOCOCCAL INFECTION IN CHILDREN, THE POSSIBILITY OF CHILD ABUSE MUST BE CONSIDERED!

The efficacy of therapeutic regimens for uncomplicated and complicated gonococcal infections of childhood is unproven at present.

Prevention of Neonatal Infection:

All pregnant women should have endocervical cultures examined for gonococci as an integral part of prenatal care.

Prevention of Gonococcal Ophthalmia:

A. One percent silver nitrate (do not irrigate with saline, as this may reduce efficacy).

B. Ophthalmic ointments containing tetracycline, erythromycin, or neomycin are also probably effective.

C. **NOT RECOMMENDED:** Bacitracin ointment (not effective) and penicillin drops (sensitizing).

Management of Infants Born to Mothers With Gonococcal Infection:

Orogastric and rectal cultures should be taken from all patients. Blood cultures should be taken if septicemia is suspected. Aqueous crystalline penicillin G, 50,000 units/kg/day, should be administered in two daily doses intravenously, if cultures or Gram-stained smears reveal gonococci. The duration of therapy should be determined by clinical response. In suspected septicemia, an aminoglycoside should also be administered.

Neonatal Disease:

A. Gonococcal ophthalmia: Patient should be hospitalized. Antimicrobial agents: Aqueous crystalline penicillin G, 50,000 units/kg/day, in two or three doses intravenously for 7 days, PLUS frequent saline irrigations and instillation of penicillin, tetracycline or chloramphenicol eyedrops.

B. Complicated infection: Arthritis and septicemia should be treated by hospitalization

and administration of aqueous crystalline penicillin G, 75,000-100,000 units/kg/day, in four doses, or procaine penicillin G, 75,000-100,000 units/kg/day, in two doses, for 7 days. Meningitis should be treated with aqueous crystalline penicillin G, 100,000 units/kg/day, divided into two or three daily intravenous doses and continued for at least 10 days.

Childhood Disease:

Gonococcal ophthalmia should be treated with hospitalization and by the administration of aqueous crystalline penicillin G intravenously, 75,000-100,000 units/kg/day, in four doses, or procaine penicillin G, intramuscularly, 75,000-100,000 units/kg/day, in two doses, for 7 days, *PLUS* saline irrigations and instillation of penicillin, tetracycline or chloramphenicol eyedrops. Topical antibiotics *alone* are *NOT* recommended in therapy of gonococcal ophthalmitis. The source of the infection must be identified.

Uncomplicated vulvovaginitis and urethritis usually do not require hospitalization. Both may be treated at one visit with aqueous procaine penicillin G, 75,000-100,000 units/kg intramuscularly, and probenecid, 25 mg/kg by mouth. Topical and systemic estrogen therapy are of no benefit in vulvovaginitis. All patients should have followup cultures, and the source of infection should be identified, examined and treated.

Infection complicated by peritonitis or arthritis should be treated by hospitalization and administration of aqueous crystalline penicillin G, intravenously, 75,000-100,000 units/kg/day, in four doses, or procaine penicillin G, 75,000-100,000 units/kg/day intramuscularly, in two doses for 7 days.

Treatment of patients with allergy to penicillin: Patients under 6 years of age should be treated with erythromycin, 40 mg/kg/day, in four doses by mouth, for 7 days, for uncomplicated disease. Complicated disease should be treated with cephalothin, 60-80 mg/kg/day in four doses intravenously, for 7 days. Patients older than 6 may be treated with an oral regimen of tetracycline, 25 mg/kg, as an initial dose, followed by 40-60 mg/kg/day in four doses, for 7 days, or an intravenous regimen consisting of tetracycline, 15-20 mg/kg/day, in four doses, for 7 days. □

Diagnosis Specificity of Culture for Gonorrhea

Among the tools available to the physician in the clinical laboratory, the culture for *Neisseria gonorrhoeae* is among the most specific. False positive gonorrhea cultures are rare (1% or less). Therefore, when a physician treats a patient for gonorrhea on the basis of a positive culture, he can be 99% sure he is treating the patient appropriately. The physician must rely heavily on the culture results, since 80% of females with gonorrhea are asymptomatic.

Guidelines followed by the U.S. Public Health Service and the State Department of Health in the diagnosis of uncomplicated gonorrhea in women are these:

- 1. Obtain culture from cervical os (rectal culture may be done at the same time);
- 2. Immediately inoculate an appropriate medium (eg Thayer-Martin plates or Transgrow);
- 3. Pre-incubate specimens that are being sent to a reference laboratory;
- 4. An isolate obtained in the above fashion is



News From The Oklahoma State Department of Health

identified as *N. gonorrhoeae* on the basis of (a) oxidase positivity; (b) colony morphology; (c) appearance on gram stain.

If these guidelines are followed, 1% or less of isolates identified as *N. gonorrhoeae* will be false positives.

The chances of obtaining a *false negative* gonorrhea culture are approximately 10%, under *ideal* conditions.

A repeat culture performed because the physician doubts that a given female patient is infected can be seriously misleading. A positive culture result is 99% reliable; the chances of confirmation are less than 90%. There is *no* advantage in reculturing a culture-positive patient prior to treatment. There *is* considerable risk of failing to diagnose an infectious patient by doing so. □

COMMUNICABLE DISEASES IN OKLAHOMA FOR APRIL, 1975

DISEASE	April 1975	April 1974	March 1975	Total To Date	
				1975	1974
Amebiasis	1	2	—	4	6
Brucellosis	—	—	1	2	2
Chickenpox	159	114	205	674	528
Encephalitis, Infectious	4	4	8	18	13
Gonorrhea (Use Form ODH-228)	1104	980	1046	4069	3385
Hepatitis, A, B, Unspecified	60	81	87	316	389
Leptospirosis	—	—	—	—	—
Malaria	—	—	—	1	1
Meningococcal Infections	1	4	4	8	11
Meningitis, Aseptic	1	5	2	9	14
Mumps	24	48	24	80	256
Rabies in Animals	8	21	15	47	50
Rheumatic Fever	4	—	—	5	3
Rocky Mountain Spotted Fever	3	3	—	4	3
Rubella	10	4	10	66	22
Rubella, Congenital Syndrome	—	—	—	1	1
Rubeola	3	2	5	18	13
Salmonellosis	6	23	13	52	72
Shigellosis	9	12	20	148	41
Syphilis, Infectious (Use Form ODH-228)	7	14	7	36	58
Tetanus	—	—	—	—	—
Tuberculosis, New Active	22	31	43	110	94
Tularemia	—	—	—	—	2
Typhoid Fever	—	—	—	—	—
Whooping Cough	8	—	2	8	5

SEVENTH ANNUAL ARKANSAS- OKLAHOMA CANCER FORUM

September 25th-26th, 1975

Fort Smith, Arkansas

This one and one-half day meeting will be held at the Sheraton Inn in Fort Smith, September 25th-26th, 1975.

Guest speakers from Memorial Hospital, New York City and the Sloan Kettering Institute will highlight the program.

Further details to be announced later.



Pro-Banthine®
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propantheline bromide

Indications: Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer. Dosage must be adjusted to the individual.

Contraindications: Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

Warnings: Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

Overdosage may cause a curare-like action, with loss of voluntary muscle control.

For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

Precautions: Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

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Medical Department, Box 5110, Chicago, Ill. 60680 481

Rondomycin[®]

(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
 Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)

All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in premature given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.

Tetracyclines are present in milk of lactating women taking tetracyclines.
 To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.

Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.

PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.

In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.

Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.

In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).

Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
 Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.

ADVERSE REACTIONS: **Gastrointestinal** (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.

Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).

Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).

Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.

Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.

Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
 Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.

USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.

For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.

Eaton Agent pneumonia: 900 mg daily for six days.

Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
 Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.

Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.

In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.

In streptococcal infections, a therapeutic dose should be given for at least 10 days.

SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest POR information.

Rev. 6/73



WALLACE PHARMACEUTICALS
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OSMA Publications Available

The following publications are available to OSMA members free of charge. Requests for the publications should be directed to the Oklahoma State Medical Association, 601 Northwest Expressway, Oklahoma City, Oklahoma 73118.

PROFESSIONAL LIABILITY MEDICAL-LEGAL GUIDE FOR PHYSICIANS: This is a 36-page booklet written to assist physicians in preventing medical malpractice difficulties.

DRUG ABUSE TREATMENT MANUAL: Prepared by the OSMA Alcoholism and Drug Committee to assist physicians in handling, on a short-term basis, drug involved patients.

INDEPENDENT PRACTITIONERS UNDER MEDICARE: A report to United States Congress from the Health, Education and Welfare Department regarding the practice of chiropractic. It is an indictment of this unscientific cult.

MEDICAL-LEGAL INTERPROFESSIONAL CODE: This is the standards of cooperation between physicians and attorneys that have been mutually adopted by the OSMA and the Oklahoma Bar Association.

MEDICAL NEWS PRACTICES: The standards of cooperation among physicians, hospitals and the press of Oklahoma, specifying the amount and types of information to be released regarding patients. It was jointly adopted by the Oklahoma Press Association, hospital association, and medical association.

FOR PHYSICIANS AND PHARMACISTS: This is the code of understanding between the Oklahoma Pharmaceutical Association and the medical association and specifies the relationship between the two professions.

All of the above materials may be ordered by OSMA members free of charge ☐

Constitutionality of PSRO Upheld By Federal Court

In a major test of the constitutionality of the Professional Standards Review Organization, a special three-judge federal court in Chicago has ruled in PSRO's favor. The ruling dismissed a suit filed in June, 1973, by the Association of American Physicians and Surgeons against HEW and the PSRO law.

In handing down its decision on May 8th, the three-judge panel said, "in upholding the constitutionality of the legislation on its face, this court does not reach the validity of the statute *as it will be applied*. Nor does this court pass upon *the wisdom of this particular piece of legislation*. Whether the implementation and application of this statute may result in an unwieldy bureaucracy of monstrous proportions is a policy question for the consideration of the legislative rather than the judicial branch of the government." (Emphasis added)

A spokesman for the AAPS stated that attorneys for the organization are reviewing the 36-page memorandum explaining the court's dismissal to determine whether or not to appeal the ruling to a higher court. He did state, however, that the organization intends to "pursue all legal remedies."

The suit as filed charged that the PSRO law violated the first, fourth, fifth, and ninth amendments to the Constitution by interfering with patients' and physicians' privacy, interfering with physician rights to practice their profession, and by not providing adequate due process to challenge PSRO decisions.

The three federal judges were William F. Pell, Thomas R. McMillen, and William J. Lynch, all sitting in the Northern District of Illinois, Eastern Division of the Federal Court. They took each of the AAPS's seven contentions and discussed them individually. The following are excerpts from the memorandum of decision that accompanied the federal court order.

The AAPS contended that the legislation violated the Fifth Amendment to the Constitution

in that it unconstitutionally interferes with their right to practice medicine. In response the court stated, "the Professional Standards Review Law does not prohibit a physician from performing any surgical operation he deems necessary in the exercise of his professional skill and judgement. It merely provides that if a practitioner wishes to be compensated for his services by the federal government, he is required to comply with certain guidelines and procedures enumerated in the statute . . .

"Underlying the constitutionality of the challenged legislation is the basic premise that each individual physician and practitioner has the ability to choose whether or not to participate in the program. It is true that there will exist economic incentive or inducement to participate in the program. *However, such inducement is not tantamount to coercion or duress.*"

In response to the plaintiff's contention that the law would interfere with physician-patient relationship by imposing a system of "norms of care, diagnosis and treatment" the court stated, "given the legislative standard of reasonableness and statutory flexibility to take into account various methods of treatment, the court finds no merit to the plaintiff's argument that the system of norms to be established under the statutory scheme will unconstitutionally interfere with the physician-patient relationship."

The AAPS also argued that the statutory sections requiring physicians to furnish information concerning their patients violated the constitutional rights of privacy. In response the court stated that the statutory "procedures are reasonable in scope in that they contain provisions designed to assure confidentiality." The court then went on to quote a decision in another federal case that stated, "Congress is simply imposing a condition on the spending of federal funds."

Another contention of the AAPS was that numerous words and phrases contained in the statute were vague and uncertain and that this vagueness violated the specificity requirement of the Fifth Amendment of the Constitution.

The court points out, "the test in determining

whether or not a statute is unconstitutionally vague is whether men of common intelligence must necessarily guess at its meaning." The court went on to state, "Congress faced a difficult task in drafting this statute with sufficient specificity to give the physicians, practitioners and providers of health care service adequate notice of the new requirements of the law and at the same time to maintain enough flexibility to cover a variety of medical cases. In accomplishing this task Congress did not stray beyond the permissible boundaries of the constitution."

Another section of the PSRO law that was challenged was that which established certain limitations of liability. The AAPS contended the Congress lacked the authority to grant legal immunity against common law tort liability and that if such immunity was unconstitutional, the PSRO law would then impose duties and obligations on physicians that could unconstitutionally expose them to civil liability.

In responding to this point, the court points out, "the possibility of exposure to civil liability sometime in future as a result of complying with the statutory norms does not amount to that type of real and immediate threat of injury which is necessary. . ." to bring a case into federal court. Courts have traditionally refused to hear cases in which there is no real issue.

The statutory requirement that physicians must provide evidence of their performance of services was also attacked by AAPS. They contended that the medical license itself carries certain presumptions of competence, good moral character, and regularity of motive and conduct.

The court cited another case in which it was held that the issuance of a license is only one of several ways of being followed by various states to regulate the practice of medicine.

The AAPS also contended that the fact that a private organization had entered into a contractual relationship with the Health, Education and Welfare Department would, *per se*, bias the organization against physicians.

The court stated that this argument was ill-founded and pointed out that PSROs, by statute, must be non-profit organizations. Membership in such a PSRO is open to every physician in the area, and all review of medical decisions would be made by a physician. The court ended by saying, "thus, plaintiff's allegation that these private organizations will be biased is totally without merit."

The court pointed out that the final argument

being advanced by the AAPS, and buttressed by a lengthy amicus curiae brief filed by the Association of Councils of Medical Staffs of Private Hospitals, Inc., was a broad attack on the legislation as an inefficient and unnecessary interference with their right to practice medicine.

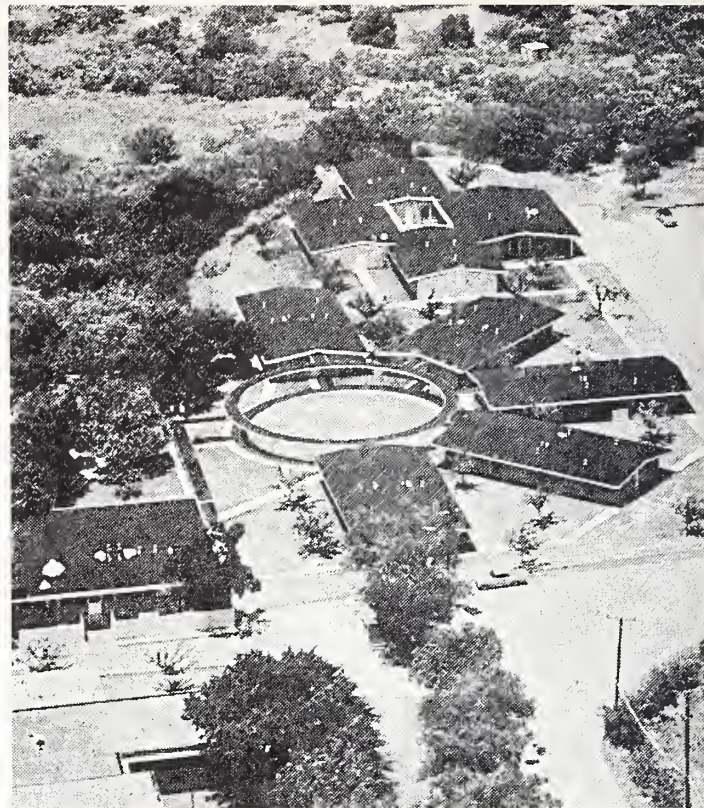
The court commented, "Congress has enacted this legislation as a vehicle to better control expenditures of the federal government in connection with the Medicare and Medicaid programs. In view of the already extensive presence of the federal government in the health care sphere, it can hardly be said that a statutory scheme designed to achieve better cost control in the field of health care is outside the competency of the federal government.

"The means that Congress has chosen to attain these economic goals are not arbitrary and totally lacking in rationality. Underlying the constitutionality of the legislation is the fact that the program is a voluntary one in which a physician may freely choose whether or not to participate. However, should a physician choose to participate, he must then comply with these requirements in order to be compensated for his services.

"This legislation represents the first medical Utilization Review Program that is national in scope. In attempting to avoid over-utilization and to achieve better cost control in the health care field, the Professional Standards Review Law comes in close proximity to the rights of those physicians and other providers of health care services in the Medicare and Medicaid programs. Yet there must be a balancing between those interests and the government interests in providing and maintaining medical care to those most in need of it.

"The Professional Standards Review Legislation properly preserves that balancing of interest. In upholding the constitutionality of the legislation on its face, this court does not reach the validity of the statute as it will be applied. Nor does this court pass upon the wisdom of this particular piece of legislation. Whether the implementation and application of this statute may result in an unwieldy bureaucracy of monstrous proportions is a policy question for the consideration of the legislative rather than the judicial branch of the government."

The court closed by issuing an order which stated, ". . . it is hereby ordered that this cause be dismissed for failure to state a claim upon which relief can be granted." □



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National Malpractice Situation Bad—Federal Intervention Could Be Worse

Congress has been told by the American Medical Association that federal legislative remedies for the professional liability crisis could create a worse situation and in some cases result in even higher liability costs.

In testimony before the Senate Health Subcommittee headed by Senator Edward Kennedy (D-Mass.) as it opened hearings on the liability issue, AMA President Malcolm C. Todd, MD, declared "it is far wiser for states to enact varied innovative legislative responses to the problem than to have an untested and unproved scheme enacted on a nationwide basis by the federal government particularly when such proposals contain elaborate provisions for federal government regulations of the practice of medicine."

While stating that there is no question that a crisis exists in medical liability insurance coverage, the AMA president went on to say, "the complexity of the problem, and its varied causes convince us, however, there is no single solution, be it arbitration, 'no fault,' or anything else."

Doctor Todd then pointed out that many states are acting on the professional liability problem. "Perhaps the eventual solution in most states will be a synthesis of various approaches . . . enactment of a federal program would eliminate the state's initiative and would establish a program that would fail to recognize individual state problems."

One of the bills currently pending before the Health Sub-committee proposes compulsory arbitration tied to licensure and relicensure of physicians, review of all physicians' services by Professional Standards Review Organizations, acceptance of federal fee schedules under Medicare and required consultation before surgery. These restrictions "have not demonstrated relationship to the problems of medical liability or liability insurance," the AMA president said. "Rather the crisis-need for remedies for these problems is being used as a device for imposition of further government meddling in the practice of medicine."

A surprised Senator Edward Kennedy has encountered a wall of opposition from the major groups involved in the medical liability crisis with the respect of federal intervention as a solution. The administration has joined the AMA, the American Hospital Association, and the American Trial Lawyers Association in urg-

ing that the federal government keep out of the liability picture at least for the time being.

Most of the suggested remedies so far carry bad news for some group, either increased governmental controls on physicians and hospitals, loss of fee income for lawyers, or some undermining of the medical consumers right to sue. In addition, insurance has always been very much a state prerogative in the United States and federal legislation that infringes on states' powers over insurance is always difficult to enact.

Washington observers now state that the likelihood of Congressional action this year on a broad liability bill appears remote. An undercurrent of opinion on Capitol Hill seems to be that the problem should be faced when a national health insurance program is considered. □

Hawaii Tour Filling Fast

Over 200 physicians and their spouses have signed up for the OSMA sponsored tour to Hawaii for the 1975 AMA Clinical Session in Honolulu.

The AMA Clinical will run from November 30th until December 5th. The OSMA tour will leave for Hawaii on November 28th and return on December 7th.

The basic tour includes roundtrip jet economy airfare from Oklahoma City to Honolulu via Braniff's 747 and all inter-island airfares. Seven nights of superior room accommodations will be furnished at the beautiful Hawaii Regent Hotel on Waikiki. The basic tour then includes two nights superior room accommodations at the magnificent Maui Surf Hotel on the Valley Island of Maui. However, there is an optional tour, costing \$51 per person extra, that is two nights at the Mauna Kea Hotel on the "big" island of Hawaii.

The basic tour price per person for superior room accommodations is \$575 or \$595 for deluxe room accommodations, double occupancy. Both prices include the two days at the Maui Surf Hotel. The Mauna Kea option adds \$51 to either price.

The tour offers physicians an opportunity to attend the entire AMA Clinical Session in Honolulu, and then take a post-convention trip to Maui. Registration should be directed to the Oklahoma State Medical Association, Attention, Don Blair, 601 Northwest Expressway, Oklahoma City, Oklahoma 73118. □



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- Electro-Convulsive Therapy
- Clinical Laboratory
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- Medical Consultations



AMA Introduces New NHI Proposal in Congress

The American Medical Association has introduced a new proposal for national health insurance into the United States Congress. Key lawmakers on both sides of the aisle in the House of Representatives are sponsors of the bill, HR 6222.

The AMA proposal is the only substantially new approach to national health insurance (NHI) presented so far in the 94th Congress. It is called the Comprehensive Health Care Insurance Act. The bill was authored by two Democrats and two Republicans: Representative Richard Fulton, a Democrat from Tennessee; John Murphy, a Democrat from New York, Tim Lee Carter, a Kentucky Republican; and John Duncan, a Tennessee Republican.

The AMA's NHI plan builds on the structure of the present system of employer-employee group health insurance plans, mandating each employer to provide comprehensive and catastrophic benefit coverage with the employer picking up at least 65% of the cost. Employees would not be compelled to participate.

The self-employed as well as the non-employed could purchase qualified private

health insurance, through pools if needed, at a cost not more than 125 percent of the cost of group plans. They would have all or part of the premium paid by the federal government depending upon their income tax liability.

Small businesses that find the mandated plan an added financial burden could receive federal assistance.

Medicare beneficiaries could purchase supplemental insurance to bring Medicare benefits up to a par with those offered elsewhere, with the government assisting people with limited resources. Medicaid would be eliminated under the program.

After a certain level of co-insurance is reached, depending upon income, insurance covers all remaining costs as a complete protection against catastrophic costs.

The co-insurance factor would depend on one of needed care. The absolute maximum that any individual would have to pay would be \$1,500, while the absolute maximum for any family would be \$2,000 in any given year.

Representative Fulton, a member of the House, Ways and Means Committee, told the House that the bill "represents the evolution of the doctors thinking on this complex subject;

and it demonstrates that the continuing process of discussion and debate has influenced the doctors as, indeed it has influenced the thinking of Congress."

"We must build on the structure of group health insurance which is today providing sound basic coverage for a vast majority of Americans at no cost to the government," the representative said. "It is easier to remedy whatever deficiencies exist in this mechanism than to junk it in favor of a new and elaborate government structure that would have to be created from scratch . . . it would also be considerably less traumatic for Americans to remain with a familiar system . . ."

Third ranking Republican on the House, Ways and Means Committee, Representative John Duncan, said in a House speech that "the AMA plan does the best job to date in identifying the line between national bankruptcy and national parsimony in expenditures for national health insurance.

"The doctors plan provides federal assistance on the basis of need. The most help goes to those who need it most. The least help goes to those who need it least."

He went on to say that the Comprehensive Health Care Insurance Act removes the fear of catastrophic illness that plagues even well-off Americans and provides weekly regular benefits, including 365 days of inpatient hospital care, 100 days of skilled nursing care, full dental care for children, home health benefits and many other services including psychiatric treatment and well baby care.

Kentucky's Representative Tim Lee Carter, a physician-member of Congress and ranking minority member of the House Health Subcommittee, said the bill "retains a large measure of pluralism in the administration and financing . . . and it is precisely this pluralism . . . the creativity and sensitivity of the private sector, supplemented only where necessary by government . . . that has made the quality of American medicine hands down the finest in the world."

Doctor Carter pointed to the cost control mechanism of "co-insurance" that is applicable to all, except for the poor, in the physicians' plan. "There is incontestable evidence that any health care system without some regulatory control is soon bogged down by the 'worried-well,' " he said.

Representative John Murphy of New York, a member of the Commerce Committee, said that

organized medicine's plan "does about what the federal government can afford to do at this particular time. It will not be legislation that over-promises and underperforms." Murphy declared, "because the program utilizes the existing structure of the private insurance industry, there can be a fast startup. There will be minimum of administrative costs and bureaucratic delays.

"This is the place to start: a sound foundation of comprehensive health services, available to all Americans, and at a reasonable cost." □

Professional Liability Guide Again Available from OSMA

The "Professional Liability Medical-Legal Guide for Physicians" booklet prepared by the OSMA is again available upon request to all physician members of the association. The booklet discusses important doctrines of law, gives a series of malpractice preventive measures that physicians can take, and includes a number of medical-legal forms to be used.

The booklet was originally prepared by the OSMA staff in 1969 and was printed by the Insurance Company of North America and distributed to all association members. It has now been republished in quantity and is available upon request by contacting the Oklahoma State Medical Association, 601 Northwest Expressway, Oklahoma City, Oklahoma 73118 or calling Area Code 405-842-3361.

In the section on Important Doctrines of Law there is a discussion of battery, consent, informed consent, discreet disclosure, professional negligence, standards of care, liability for the acts of others, and the two doctrines known as "captain of the ship" and "res ipsa loquitur."

Another section of the book contains a number of medical-legal forms, 14 in all. In addition, it also contains four form letters that might be of use to a physician: a letter to confirm discharge by a patient, a letter of withdrawal from the case, a letter to the patient who fails to keep appointments, and a letter to a patient who fails to follow advice.

In addition to the booklet, speakers on malpractice prevention are available from the OSMA to talk to county medical societies, hospital staff meetings, clinic staff meetings, etc. Arrangements for these speakers may be made through the OSMA, Attention Ed Kelsay, Associate Executive Director. □

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Alcoholism Treatment Center In Cushing, Oklahoma

Another Valley Hope Alcoholism Treatment Center, the third of its kind, was just recently opened in Cushing, Oklahoma. This center came about through tireless efforts of a group of Oklahomans who recognized a need for alcoholism treatment in Oklahoma as embodied in the Valley Hope Program. The Cushing Valley Hope Treatment Center opened on June 3rd, 1974 and since then has been offering hope and a start toward lasting sobriety to suffering alcoholics and their families.

From a shoestring start in August, 1967, the unique program of Valley Hope was conceived and begun in Norton, Kansas. By August 28th, Valley Hope had a staff of ten, plus three Norton physicians and ten patients. Two weeks later the state licensed it as a qualified psychiatric unit hospital. More patients followed. Kansas Blue Cross-Blue Shield then accepted Valley Hope as a non-member hospital to pay up to 80% of treatment costs for member patients. This was a major breakthrough and since then 29 other health insurance companies have approved Valley Hope Centers.

Purchase of a five-year-old motel in Norton, Kansas, which would house 68 patients was accomplished through tireless fund-raising efforts by many dedicated persons. Occupancy of the new facility took place in November, 1968. Since this time the Valley Hope Association, a private, non-profit organization has come to consist of inpatient centers at Norton and Atchison, Kansas and the new center at Cushing, Oklahoma. The association also operates outpatient counseling and referral offices at Overland Park, Wichita, and Abilene, Kansas.

Doctor Wm. D. Leipold, Clinical Director of the Valley Hope Association, states: "We treat the alcoholic as a person, a human being. One of the first goals is to re-establish their human dignity, which means we operate on a concept of trust. There are no locks or bars on windows or doors. Anyone is free to come or go. The program spends very little time delving into the past, digging into the archaeology of why the patient developed alcoholism. The concentration is on: 'What are you going to do about it now?' The patient is shown how he or she must become responsible for his or her own behavior; is taught how he or she can grow up and leave the childish behavior habits of the drinking alcoholic behind."

Cushing Valley Hope Alcoholism Treatment

Center contains fifty-one patient rooms, dining facilities, large lecture hall, rooms for counselor offices and therapy groups, and recreational facilities including a swimming pool. An informal, relaxed, homelike atmosphere is maintained for our patients. This facility is a major step in Valley Hope's efforts to continually find a better . . . more efficient way to deal with the dread disease of alcoholism.

For more information or for help for yourself or a loved one regarding alcoholism or related problems, call or write: Valley Hope, P.O. Box 47, Cushing, Oklahoma 74023. Phone: (918) 225-1736. □

Medicare/Medicaid Allowables to be Reduced

A ceiling on physicians' allowable fees under Medicare and Medicaid is being put in place by the Bureau of Health Insurance. The ceiling was mandated by Public Law 92-603, the Social Security Amendments of 1972.

A portion of that law specified that there was to be a ceiling on physicians' fees based on physicians' charges for calendar year 1971 plus an increase related to an "economic index."

The initial regulations, published April 14th, did not specify exactly what the "economic index" was to be. Later it was announced that this would be the "cost-of-living" indexes.

The announcement that physicians' reimbursements would be tied to the cost-of-living index drew immediate and angry responses from the American Medical Association.

Richard E. Palmer, MD, Chairman of the AMA Board of Trustees, charged that there was an "appalling lack of the most elementary and essential information" about the proposal, which he termed "another federal attempt to copout on previous commitments to the elderly and to shift most of the burden onto the individual patient and the physician."

HEW gave 30 days for interested parties to comment on the proposed regulations published in the Federal Register. Doctor Palmer said, "we've been given just 30 days to respond to a whole new set of HEW regulations to put a lid on Medicare reimbursement rates. Since the proposed regulations relate to a law passed over two years ago, we think we're entitled to a minimum of 60 days to examine them and reply."

The Board Chairman then went on to point

out the key parts of the regulations were not even available and that HEW had not supplied data that they were using to arrive at "examples" of how the new regulations might be applied.

Recent information from Medicare indicates that the formula published in the register would allow approximately an 18 percent increase over 1971 charged data. This would mean that many charges currently being recognized by Medicare and Medicaid would be reduced.

L. E. Rader, Director of the Oklahoma Department of Institutions, Social and Rehabilitative Services, strongly objected to the new regulations in a letter to J. B. Cardwell, Commissioner of Social Security of the Department of Health, Education and Welfare. Mr. Rader stated, "the regulations as proposed would result in significant, widespread reduction of allowable charges below the current allowable charges. On unassigned claims, this will result in reduced payments to beneficiaries and could result in a sharp decrease in assignments. Many beneficiaries will be asking why Medicare is paying lower allowable charges than previously. For the protection of the beneficiaries, recognition should be taken of the (Department of HEW, delay in implementation of this section of Public Law 92-603 and the economic index should include an adjustment factor to insure that *in no instance* will this result in a lower allowable charge than was allowed in fiscal 1975.)" Emphasis added.

Mr. Rader also objected to the fact that the "economic index" as listed in the Federal Register was not spelled out in detail. He went on to say, "because of the extreme importance of this index, we believe it should, pursuant to the requirements of the Administrative Procedures Act, be published in proposed form." He also stated, in agreement with the American Medical Association's contention, that a minimum of 60 days comment time should be given.

Preliminary figures would indicate that many fees would be reduced below that being currently allowed by Medicare. As an example, an initial office visit with complete diagnostic history and physical examination would be decreased, as would an initial home visit, initial hospital visit then followup hospital visit for general practitioners. Internal medicine specialists would have decreases for an initial

office visit with a complete diagnostic and history on an old patient, an initial office visit with a complete diagnostic and history on a new patient, followup office visit, a followup office visit requiring more than routine work, an initial home visit, and an initial hospital visit.

Orthopedic surgeons would see a slight increase in the fee for a hip replacement prosthesis, but a decrease for an amputation through the femur.

It is projected there would be far more decreases, than increases, in the allowable charge under the new regulations. □

Doctors and Lawyers to Have Balkan Adventure

Oklahoma physicians and lawyers will be taking an exclusive two-week charter holiday to Eastern Europe and the Balkans. Cities to be visited include Bucharest, Romania; Istanbul, Turkey; Dubrovnik, Yugoslavia; with a side trip available to Kiev, Russia.

Arrangements for the tour were made through INTRAV, a company that has spent years developing deluxe personalized vacations at charter cost savings. The tour is being sponsored in Oklahoma by the OSMA and the Oklahoma Bar Association simultaneously. It will depart from Oklahoma City on July 23rd, and the cost, which includes direct flights via chartered jets, accommodations at the very finest hotels, full American breakfasts and gourmet dinners at a choice of the finest restaurants, is only \$1,128 per person.

The Balkan Adventure is not a tour, in the traditional sense of the word, it is a nonregimented holiday designed to give the traveler a maximum amount of free time in each city. Even though the trip is nonregimented, a travel director and five hosts are available to assist travelers in each city. Optional sight seeing tours are available each day for those persons wishing to go on them.

The adventure begins when travelers board a chartered World Airways DC8 jet in Oklahoma City on July 23rd. The jet features stretchout extra comfort seating, first class meals, complimentary champagne and cocktails, and direct no-change flight to Bucharest.

Bucharest is Romania's 500-year-old capital. There is always a feeling of anticipation just knowing you are behind the Iron Curtain, yet the place is friendly and easygoing.

This part of Europe was the source of many superstitions. One of the best known of which is the vampire. Don't miss the brooding castle of Count Dracula in the nearby countryside of Transylvania.

An optional side trip to Kiev, Russia, is available from Bucharest.

Second stop on the trip is Istanbul, due to its frenzy, a remarkable contrast to placid Bucharest. This is the city of intrigue. Here is the fabled Blue Mosque of Sultan Ahmed and Sancta Sophia built by Constantine in 325 A.D.

Night clubs feature belly dancers and Turkish folk dancing. The traditional dish, shish kabob, should be tried with a glass of good Turkish beer. Optional side trips are available to Izmir and the ancient ruins of Ephesus.

Last stop on the trip is the calm and ancient walled city of Dubrovnik, Yugoslavia. Residents of the city take great pride in their churches, monestaries, art galleries, museums and hundreds of apartment houses. For an unusual dining experience, how about a dinner in a Benedictine Abbey on a nearby island?

Reservations for the Balkan Adventure may be made by contacting the Oklahoma State Medical Association, 601 Northwest Expressway, Oklahoma City, Oklahoma 73118. A \$100 per person deposit is required. □

MD Prescription Deficiencies Cause Pharmacists Trouble

Several pharmacies throughout the state have recently discovered that the state law requiring certain information to appear on prescriptions before they are filled will be strictly complied with. The Office of the Commissioner of Narcotics and Dangerous Drugs Control for Oklahoma has sought District Court Action against pharmacists for failure to comply with the requirements dealing with controlled substances.

In a letter to one such pharmacy Acting Commissioner Dale Dowdy pointed out that the records of the pharmacy indicated 35 prescriptions in a six month period had not contained the patient's address, 37 did not have the prescribing physician's DEA number, four did not have the date of the order, and 25 were either not signed and/or dated by the pharmacist filling the order.

All of these irregularities are violations of both the federal and state laws on dangerous control substances. Although charges against

the pharmacy were dismissed, the pharmacists did suffer a loss in that the controlled dangerous substances seized from his pharmacy were destroyed pursuant to Oklahoma statute.

Many of the deficiencies found in the prescriptions were in information required to be put on the prescription by the prescribing physician. One federal narcotic agent commented that most pharmacists are reluctant to refuse to honor a prescription even though it is not filled out properly.

The state law requires that prescriptions for controlled substances must be written with ink, indelible pencil or typewritten and must be manually signed by the physician. The prescription can be prepared by a secretary or agent, but it must be signed by the physician.

The prescription must specify the date of its issue, the full name and address of the patient, the name and quantity of the controlled dangerous substance being prescribed, directions for its use, and the name, address, and DEA number of the prescribing physician. □

Governor Boren Seeks Doctors for State

Governor David Boren is actively involved in a "selling" campaign to encourage Oklahoma-educated physicians to stay in the state to practice or return to the state if they sought post-graduate education elsewhere.

Letters have gone out to the University of Oklahoma College of Medicine graduates of the past five years who are out of state or in the military urging them to consider some of the fine communities in Oklahoma who need their services. He is also writing 1975 graduates urging them to stay in touch with a free "physician placement service" so they will be aware of practice opportunities in Oklahoma although they may be in residency programs outside the state.

These efforts by the Governor are being coordinated by the Oklahoma Council for Health Careers, Inc., a private non-profit corporation designed to recruit young people into health careers starting in 1967. They undertook the task of locating physicians for small Oklahoma communities whose plight seemed desperate by developing a matchmaking service. Physicians complete an application form, and community leaders answer seven pages of questions about things doctors might want to know in considering a particular community.

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DEATHS

GERALD E. CRONK, MD
1919-1975

Tulsa internist, Gerald E. Cronk, MD, 55, died April 23rd, 1975. A native of Tulsa, Doctor Cronk was the brother of Robert T. Cronk, MD, also a Tulsa internist. He was graduated from Duke University School of Medicine in 1944. Following two years in military service, he took his residency at Maryland General Hospital, Baltimore and the Veterans Administration Hospital in Oklahoma City. In 1951 he entered practice in Enid.

Doctor Cronk was a member of the American Board of Internal Medicine and the American College of Physicians.

EUGENE G. WOLFF, MD
1901-1975

Eugene G. Wolff, MD, retired anesthesiologist, Tulsa, died April 12th, 1975. Doctor Wolff received his medical degree from the University of Oklahoma College of Medicine in 1934. He practiced in Tulsa for 30 years before his retirement in the late 1960s.

Doctor Wolff was a Fellow of the American College of Anesthesiologists and a Life Member of the Oklahoma State Medical Association.

DELBERT G. SMITH, MD
1903-1975

Delbert G. Smith, MD, an Oklahoma City physician since 1930, died May 13th, 1975. In addition to his private practice, Doctor Smith was Professor Emeritus and a 33-year Obstetrics Professor at the University of Oklahoma College of Medicine, where he was graduated in 1929.

A native of Arcadia, Oklahoma, he was prominent in his medical affiliations, having served as President of the Oklahoma City Chapter of the OB-GYN Society. He performed the first Caesarean section on closed circuit television in 1951. He was a Life Fellow of the American College of Obstetricians; a Life member of the Oklahoma State Medical Association; and held memberships in the International College of Surgeons, the Southern Medical Association, the Central Association of Obstetricians and Gynecologists and the Oklahoma City Clinical Society.

RUSSELL W. LEWIS, MD
1906-1975

Sulphur physician, Russell W. Lewis, MD, 68, died May 4th, 1975. A native of Drummond, Doctor Lewis was graduated from the University of Oklahoma College of Medicine in 1932. He practiced in Clinton for a while before moving to Sulphur. □

Oklahoma Affiliate Appointed By ADA

The Greater Oklahoma City Diabetes Association has been appointed the Oklahoma Affiliate by the American Diabetes Association. This makes responsibilities statewide instead of just areawide.

New offices were opened May 1st and the proper mailing address is American Diabetes Association, Oklahoma Affiliate, Suite 146, 2801 N.W. Expressway, Oklahoma City, Oklahoma 73112, Telephone 405 842-8839. □

Social Security "Broke" by 1980

1980 may well see the bankruptcy of the Social Security Administration according to a recent report in the newsletter of the Insurance Economic Society of America. The report stated that actuaries for SSA report that unemployment and inflation are throwing the retirement system into deficit sooner than forecast.

The deficit is causing outlays to exceed receipts this year by \$2.5 billion, leaving reserves at \$43.4 billion, and by 1980 only \$800 million will be left in reserves. □

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| 4. Pulmonary Function and Blood Gases | Cardiopulmonary Resuscitation (CPR) |
| 5. Fluid and Electrolyte Balance | |

*Courses 1 through 7 are 6 hours each; each is presented twice (once on Saturday, once on Sunday). Course No. 8 is a 12-hour course that runs both days.

Sites

Minneapolis, Minn. - July 26-27, 1975
Williamsburg, Va. - September 27-28, 1975

For more information **WRITE:**

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LETTERS FROM THE EDITOR; II

Mr. John Public
Hometown, USA

I deeply regret that I was unable to obtain hospitalization for you following your most recent office visit. As you know, I was — and I remain — convinced that your illness can best be treated only in the hospital. I can accept no alternative plan of treatment without, in my professional judgment, jeopardizing your health.

Although I completed all the necessary forms and satisfied all the government requirements relating to your hospitalization, the Pre-Admission Utilization Review Committee (PAURC) disagreed with my conclusions and denied your admission to Community Hospital. The Chairperson of the committee, in a personal telephone conversation this afternoon, assured me that your case had been carefully and thoroughly reviewed by the expert members of the committee, that the majority of them favored denial of my request and, as a final remark, reminded me that if I ignored the decision of the committee and succeeded in placing you in the hospital in spite of it, none of your tax-supported "health insurance" would pay for your care. When I told him/her/it that you had adequate "private insurance," he/she/it replied that none of the so-called private insurance policies would provide remuneration for hospital expenses or physicians' fees unless the hospitalization had been sanctioned by the PAURC.

You will recall, Mr. Public, that you refused to enter the hospital unless your "insurance" paid its stipulated share of the costs as you had no savings and were unwilling to burden your wife and children with such a debt. Thus, I

have no choice but to advise you that I must resign my role as your physician and suggest that you immediately select another doctor to manage your case. Since the Chairperson of the PAURC implied that the members of the committee believed that some alternative to hospital-care was appropriate, and since I can accept no alternative, I am suggesting that you contact the Chairperson for his/her/its recommendations concerning your future care.

I suppose, Mr. Public, that we can consider my resignation from your case as an involuntary referral to an uninvited consultant. I would feel a bit better about the whole affair if I were acquainted with our consultant — or if I had any information about his credentials. However, since he is paid by our government, and was appointed to such a powerful and responsible position by our government, I am certain that he has your best interests at heart and that he is a competent and unusually talented person.

In closing, I wish to thank you for selecting me as your physician during these past twelve years. I will miss having you as my patient and I sincerely hope our personal friendship will continue. Also, I want to thank you again for the countless hours and dollars you have given to Community Hospital, especially during the fifteen years you served as a member of its Board of Trustees.

Please accept my very best wishes for your continued good health. If I can be of any service to you or your new physician, please feel free to contact me.

Very cordially,

Mark R. Johnson, M. D.

P.S. Perhaps I should advise you that the members of the PAURC are not, by law, liable for any of their "official" actions. *MRJ*

AMA Annual Assembly, 1975

The 124th Annual Meeting of the American Medical Association, held in Atlantic City, New Jersey, is now history. While the scientific portion of the meeting covered a good cross section of medicine, and the scientific sessions were well attended, the primary subjects of discussion were professional liability insurance for physicians, newer scientific endeavors, and a dues increase to meet the increasing financial demands of the association.



The AMA is undergoing the most radical changes in the history of medicine. Such words and phrases as "collective bargaining," "unionism," "new militants," "aggressiveness," and "strike," are now coming into common usage. Just two years ago these words would have horrified our association's leaders. These words have evolved in our fight for continued freedom for our patients as well as ourselves.

During recent months many indiscriminate federal regulations have been written and published. Physicians are becoming increasingly alarmed at the number and severity of these regulations, for many of them not only adversely affect the quality of medical care, but also withdraw financial assistance to the poor and elderly. Examples include the Utilization Review Regulations of late 1974, the mental retardation housing regulations, and the upcoming rollback of Medicare reimbursements under Section 224 of Public Law 92-603.

All of these examples represent financial cutbacks in federal funds that have been promised to the poor, the elderly and the disabled. Many of these cutbacks result from regulations that were not written by elected leaders, but by federal bureaucrats in Washington.

The House of Delegates of the AMA approved the Board of Trustees recommendation to increase annual dues to \$250. Our Oklahoma AMA Delegates fought for a more modest dues increase. It is my opinion that the reason the dues increase did go through is that the AMA Board of Trustees has demonstrated a much more responsible and responsive attitude.

In the future we can expect the AMA to be more aggressive in fighting our battles. They have already demonstrated their ability with the federal court attack on the utilization review problem. Dur-

ing the debate on the floor of the House of Delegates the leadership was warned time and time again that the membership would expect the increased dues to be spent responsibly. It is anticipated that many more of the indiscriminate federal regulations coming out of HEW will be tested in the courtroom if necessary.

Many of these regulations are being challenged at the local level in Oklahoma by the OSMA's Public Policy Council. I would encourage you to send your \$100 contribution to the OSMA for this battle. Doctor Joe Crosthwait is chairing this important council and is devoting many hours to it each week. Please read the report of the Public Policy Council activities on page 228 of this publication.

In regard to malpractice, we in Oklahoma are indeed fortunate to have our professional liability insurance with the Insurance Company of North America, INA. Our insurance rates remain among the lowest in the United States. Number of claims filed against physicians remains low and, consequently, the losses are low.

Many times I am asked why we have it so good in Oklahoma. There are several reasons for this. First and foremost, it just seems to be a way of life in Oklahoma for people to trust people. Second, I believe our juries in Oklahoma are fair. Third, the physicians are well-trained and we have an ongoing physician educational process that helps prevent lawsuits.

We do have a distressful professional liability insurance problem attempting to force its way into Oklahoma, however. One insurance company is attempting to place a different type of liability insurance on the market. This is known as a "claims made" type policy. The "claims made" policy only renders coverage while the policy is in effect.

The deteriorating professional liability insurance situation nationally, and the AMA's battle to do something about it, reinforces my belief that AMA membership is now more important than ever before.

With the new members that the AMA House of Delegates elected to its Board of Trustees, it would appear that our national headquarters would be more responsive than ever before. I believe the investment of \$250 per year in AMA will be the very best investment ever. I think every physician in this country should be a member of AMA and pay his or her own fair share for security to practice medicine without governmental or other third party interference.

Arnold G. Nelson, M.D.

Yesteryears' Diagnosis

ED L. CALHOON, MD

*Acceptable diagnosis and excellence
of the same have evolved oftentimes
as slowly as the truth they bring.*

Laws 1961 — page 604 SB No. 81 enacting sections 931-955 concerning unexplained deaths became law on January 2, 1962. The above statute was in no small sense the result of capable, energetic and keen acumen on the part of a young physician in Tulsa, Dean Hyde, MD. This young G.P. refused to sign a death certificate without autopsy and thus uncovered the arsenic poisoning death of one Sam Doss by his wife Nannie Doss. Further investigation led to the disinterring of previous husband, nieces and nephew whose remains were all laced with arsenic. Some twelve of these were disinterred and many more deaths suspect.

The Nannie Doss case gave needed impetus to the archaic Coroner's Inquest and led to scientific investigation of all unexplained deaths as outlined in the law.

Time evolves many things, but few decisions in medicine have been more important to Oklahoma than Medical Examiner's Laws. True to their day, many astute physicians

without benefit of sophisticated laboratory techniques did, indeed, predict with accuracy and exactness the true cause of death. Others remote from medical centers without recourse to any updating literature were little better than calculated guesses. World Wars I and II brought into sharp focus the value of autopsy and clinical correlation of many diseases which had previously not been understood, nor their pathology evident.

Oklahoma's physicians have been fortunate in having a basic and ever changing and updating of diagnosis of disease and its relation to death. The Medical Examiner's laws have caused many physicians to give more than idle thought when presented with a death certificate. Though "Natural Causes" is still an acceptable diagnosis of cause of death, today's physicians are ever more aware of necessity of accurate diagnosis and the far reaching consequence of the failure to report exactness of deaths. Yesteryears' certificates contain many

A 1951 graduate of the University of Oklahoma College of Medicine, Ed L. Calhoon, MD, is a general surgeon in Beaver, Oklahoma. He is a Preceptor at the University of Oklahoma Health Sciences Center. He served as President of the Oklahoma State Medical Association in 1970-71 and is presently a Delegate to the American Medical Association. He is a member of the Rural Health Council of the AMA.

humorous, yet pathetic, diagnoses. Search of several funeral home records has yielded some of the more popular diagnoses on death certificates. For children, "Cholera Infantum" and "Cholera Morbus" was a favorite diagnosis. And the diagnoses for children did not run the gamut of absurdity as did other diagnoses on adult certificates. In no case had autopsy been done nor tissue exam made (CA of Duodenum — very rare, autopsy necessary for Dx). Below are a few of the diagnoses, note the spelling in certain cases:

1) Heart Cramp, 2) Dislocation of the Heart, 3) Sudden Death, 4) Reflex Action of Nerves following Stomach Complaint, 5) Accidental Injury, 6) Dragged by Tractor, 7) Chronic Diarrhea, 8) General Breakdown, 9) Killed in Runaway, 10) Cancer of the Duodenum, 11) Auto Intoxication, 12) Broken neck caused by falling while having a fit, 13) Liver Complaint, 14) Vertigo, 15) Heart Trouble, 16) Gangrene following miscarriage, 17) Inflammation of the Brain, 18) Old age, 19) Stomach Trouble, 20) Indigestion, 21) Flux, 22) Not Known, 23) Stoke's Disease, 24) Acute Mania, 25) Dysentery, 26) Paralysis of the Heart, 27) Granolia,

28) Paralisis, 29) Loss of Red Corpuscles, 30) Inflammation of the Bowels, 31) General Paresis of the Insane, 32) Hydropericarditis, 33) Measles and Asma, 34) Injury in Runaway, 35) Congestion of the Bowel. Another popular cause of infant death which of course was acceptable, was "Overlain."

Contemplating the above diagnoses, one is touched by the lack of scientific thinking, and yet these were acceptable diagnoses of the time.

In discussing death and the cause of death, doing an autopsy *per se* just for the record, I feel is perhaps an unnecessary procedure when one ponders the natural course of certain well documented diseases and the inevitable consequence of the same. I think perhaps autopsy is over done and the Medicare and Hospital zeal for autopsy is not necessary. This article was written in hopes it would bring to the attention of the Medical Examiner and the physicians interesting diagnoses that were encountered in the past and make us more aware of Medicolegal problems we now face in the official documentation of death. ☐

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OSMA Publications Available

The following publications are available to OSMA members free of charge. Requests for the publications should be directed to the Oklahoma State Medical Association, 601 Northwest Expressway, Oklahoma City, Oklahoma 73118.

PROFESSIONAL LIABILITY MEDICAL-LEGAL GUIDE FOR PHYSICIANS: This is a 36-page booklet written to assist physicians in preventing medical malpractice difficulties.

DRUG ABUSE TREATMENT MANUAL: Prepared by the OSMA Alcoholism and Drug Committee to assist physicians in handling, on a short-term basis, drug involved patients.

INDEPENDENT PRACTITIONERS UNDER MEDICARE: A report to United States Congress from the Health, Education and Welfare Department regarding the practice of chiropractic. It is an indictment of this unscientific cult.

MEDICAL-LEGAL INTERPROFESSIONAL CODE: This is the standards of cooperation between physicians and attorneys that have been mutually adopted by the OSMA and the Oklahoma Bar Association.

MEDICAL NEWS PRACTICES: The standards of cooperation among physicians, hospitals and the press of Oklahoma, specifying the amount and types of information to be released regarding patients. It was jointly adopted by the Oklahoma Press Association, hospital association, and medical association.

FOR PHYSICIANS AND PHARMACISTS: This is the code of understanding between the Oklahoma Pharmaceutical Association and the medical association and specifies the relationship between the two professions.

All of the above materials may be ordered by OSMA members free of charge ☐

Famous Scientific Hoaxes

Part 1. The Piltdown Hoax

ERNEST LACHMAN, MD

The Piltdown affair is one of the greatest scientific hoaxes in history and involves one to five scientists whose participation remains an unsolved mystery.

A recent editorial in this *Journal*, entitled "A Biomedical Watergate" called attention to an apparently faked series of experiments which seemed to indicate that in transplantation experiments the rejection of grafts could be avoided if the transplants, such as skin, cornea, or adrenal gland could be maintained in tissue culture for a period of 10 days. Several scientists were unable to confirm these results or withdrew from the work in frustration and disappointment. In 1974 the denouement finally came when the perpetrator of this hoax was proved to have darkened the skin of two white mice with a felt-tipped pencil in the areas where the animals had been grafted with skin from black mice. Other experiments by the same researcher, particularly on corneal transplants, likewise proved to be based on deception.

There are almost as many motivations for perpetrating such scientific hoaxes as there are scientists or pseudo-scientists committing them and generalizations as to the subjective reasons of the culprits are best avoided. The importance of these deceptive fabrications makes it worthwhile to look at some outstanding bioscientific hoaxes which have influenced and misled prominent scientists in the pursuit of their research. Tremendous energy had to be expended to uncover the frauds. The results of the discovery of these hoaxes are often quite inconclusive and while there remains no doubt that a deception has been committed, it is frequently not clear who perpetrated the fraud and for what reasons.

In its definition of hoaxes, Webster's Unabridged Third Edition lists the Piltdown forgery as "one of the biggest hoaxes ever launched on the scientific world." This fabrication led to one of the most famous bioscientific controversies in history and absorbed the working energy of many outstanding paleontologists and anthropologists of this period. The whole Piltdown affair represents a tragedy which comprises an accumulation of unbelievable human errors and deceptions. The details of these have been presented in two books and several hundred articles and chapters in books and can be reported here only in compressed form. The main sources of this narrative are given in the bibliography.

The event centers around Charles Dawson, a solicitor and antiquarian, who at the time of the Piltdown discovery already had made a name for himself as an amateur paleontologist, and gradually involved most of the prominent anthropologists of Europe and many scientists in this country. In December 1912, at a meeting attended by many British geologists, Dawson presented to the public his sensational find of fragments of a remarkably thick human skull cap and the right half of an ape-like mandible with two molars. According to Dawson the finds were made over a period of four years in a gravel pit on Piltdown Commons in Sussex. Later two human nasal bones and fragments of a turbinate bone were recovered with the assistance of the distinguished French archaeologist, Father Teilhard de Chardin, and the active support of Sir Arthur Smith Woodward, an eminent paleontologist at the British Museum in London of impeccable reputation. All these skeletal remains represent Piltdown man I, or "Eoanthropus Dawsoni." After Dawson's death in 1916, Woodward supplemented these findings by pieces of a second human skull and a molar tooth, which originated in the same geographic area and represented the so-called Piltdown II skull. From petrified remains of extinct animals such as elephants and mastodons and primitive flint implements from the same gravel pit the find could be dated as originating in the early Pleistocene epoch. As such they were at least half a million years old as compared to the 100,000 years old Neanderthal man. After reconstruction from the fragments, the findings evolved as "Piltdown or dawn man," or "the earliest Englishman," as his proponents called him. He had an astonishingly human cranial vault with steep forehead of modern man and hardly any brow ridges, but displayed the lower jaw of an ape. This combination seemed

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to represent Darwin's missing link in the chain between ape and man and apparently gave indisputable proof of man's ape-like ancestors. Thus, a new evolutionary theory of man's origin had apparently been uncovered as compared to the pre-human fossil remains from South Africa, Java, Peking, and Neanderthal which were characterized by a simian-type skull with a low forehead and very prominent brow ridges and a more human-like jaw, chin and teeth. In contrast the Piltdown man displayed just the reverse features: a human-type braincase and an ape-like jaw. These two lines were irreconcilable and no common ancestor for the diverging lines could be envisaged (Weiner). The conflict evoked a controversy that is unequalled in the history of paleontology and raged for more than 40 years. The combatants could be divided into monists, who contended that skull and jaw belonged to the same individual, and dualists who rejected the theory that cranium and jaw were part of one skeleton and contended that the cranial vault was that of a fossil, yet rather modern type of man, but that the jaw belonged to an anthropoid ape. They asserted that their association in the same gravel pit was purely accidental. To the monistic group belonged — in addition to Woodward — the famous Australian paleontologist Sir Grafton Elliot Smith, Teilhard de Chardin, and Sir Arthur Keith, the curator of the Museum and Hunterian Professor of the Royal College of Surgeons of England and one time President of the Royal Anthropological Institute of Great Britain and author of numerous scientific works. Keith as the most vocal advocate of "Eoanthropus Dawsoni" asserted that Piltdown man originated much earlier than Neanderthal man, yet showed many more modern characteristics than the latter. According to him the discovery of Dawson and Woodward was of greater importance than the originators were aware of. In contrast to their more modest claims, Keith stated that they had found Pliocene man, not Pleistocene man, which expressed a difference in age of more than one million years. He further insisted that the volume of Piltdown man's brain was as large as that of modern man.

The dualists were mostly American and German, among them the famous anatomist and paleontologist, Weidenreich. They identified the jaw as that of a chimpanzee or orangutan.

In order not to lose our perspective, we should recognize that throughout this period of

controversy Piltdown man as a concept was far from being universally accepted, particularly in the later years of the debate. A third group not pretending to know the answer to the puzzling data suggested that the Piltdown find be put aside or ignored until additional evidence became available, an evasive response to the problem that did not contribute to its solution.

Charles Dawson, Piltdown man's discoverer, acquired widespread fame and only his early death in 1916 deprived him of a knighthood and a royal pension. Twenty years later his accomplishments were commemorated by the erection of a memorial stone at the site of his finds. On that occasion, Sir Arthur Keith gave an eloquent oration to a large audience, in which he celebrated the tremendous achievement of an amateur paleontologist and compared his accomplishment to the discovery of Neanderthal man.

Forty years later in November 1953, came the denouement with the announcement by three famous British anthropologists from the Department of Anatomy at Oxford in cooperation with the Department of Geology at the British Museum, that Piltdown man was a fraud. They demonstrated quite clearly that the mandible and canine tooth are those of a modern large ape which had been skillfully doctored by filing, abrasion, and chemical staining to simulate the fossilized material of the skull cap. The scientists proved without doubt that the cranial fragments, except for their thickness, represent a modern type of human calvarium which in no way differs from other fossilized human bones found elsewhere. It was probably not more than 600-700 years old (Kenneth Oakley). It was furthermore shown by sophisticated methods that the fossilized bones of extinct animals found with the human fragments did not originate in Britain, but were imported, probably from a site in Tunisia and that the tools, such as fossilized elephant bones, had been worked over with modern instruments and the flint stones had been superficially colored with chromate and iron stains.

Thus, the Piltdown hoax which seemed to introduce such an insoluble riddle of a freakish human-like being with "a modern thinker's forehead and jutting simian jaws" and which had puzzled and embarrassed scientists for more than 40 years, had finally been exposed. Nothing remained but the fact that many out-

standing scientists of this era had been duped by an unscrupulous fraud "that finds no parallel in the history of paleontological discovery".

There remains the question: what kind of man did commit this hoax? He must have been an individual that combined profound knowledge of anatomy, paleontology and geology with outstanding technical skill. Was Dawson, who seemed the most likely suspect at the time of the uncovering of the fraud, such a person? Authorities of the period seemed to think so. J. S. Weiner, who as one of the three British scientists so actively participated in the denouement of the hoax, seemed to think so in his book *The Piltdown Forgery* which appeared in 1955. But, as he concedes, there is no positive and final proof of Dawson's guilt. Weiner hints that Dawson might have thought of his undertaking as a "joke" that got out of hand, but he was not an "anti-Darwinist" or anti-evolutionist who might have gone through a good deal of trouble to compromise the theory of evolution. In a more recent book published in 1972, the author, Ronald Millar, regards — in addition to Dawson — at least four other men, all well-known scientists, as possible participators in the deception. Like others before him he states that Piltdown man was a hoax that went sour. According to him the deception was certainly not intended as a forgery that could stand the test of time. He actually finds one of the participating researchers more suspect than Dawson.

The Piltdown hoax was a tremendous waste of time, energy, and brainpower that confused the authorities for many years and retarded the progress of science. If anything can be learned from the affair, it is that in the future scientists will have to be more skeptical in accepting surprising data and theories. In disproving the existence of Piltdown man, fluorine, nitrogen and uranium assay techniques could have been applied considerably earlier. Some of the involved scientists even worked only from plaster casts instead of the actual bones. Today, carbon (C-14) or the recently introduced potassium-argon dating would have easily uncovered the fraud. The most likely motive for the perpetration of this deception must have been a tongue-in-cheek or "smarter than thou" approach on the part of the culprit or culprits. Webster's older definition of a hoax (in the Second Unabridged Edition) seems to fit the case perfectly: "A deception for mockery or mischief; a deceptive trick; a practical joke." In

our case it was a practical joke of monumental dimensions.

In closing, however, one must concede with Weiner, "that there is no doubt about the reality of transformation which has brought Man from his simian status to his sapiens form and capability." □

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NOW AVAILABLE

PROFESSIONAL LIABILITY MEDICAL — LEGAL GUIDE FOR PHYSICIANS

PUBLISHED BY OKLAHOMA STATE MEDICAL ASSOCIATION

This booklet was prepared by the staff of the OSMA in 1969 and was published by the Insurance Company of North America for distribution to all medical doctors in the state. It has now been republished and is available upon request.

Requests for the book should be directed to the Oklahoma State Medical Association, 601 Northwest Expressway, Oklahoma City, Oklahoma 73118.

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Full Employment Opportunity: Does It Exist for the Handicapped?

CINDY MILLER

This is the first place winning essay in the "Ability Counts" contest which is sponsored by the Governor's Committee of Employment of the Handicapped. The OSMA contributes a \$250 expense-paid trip to Washington, DC, for the teacher of the first-place winner. The author, Cindy Miller is a student at Putnam City High School.

A caterpillar spins a cocoon around himself and hides within it. The cocoon hangs lifeless among the green-colored leaves, almost hidden and unnoticed. Finally, after a long wait, the cocoon splits, and from it emerges a butterfly, eager to begin life again.

A handicapped person, like the caterpillar, builds a cocoon around himself and hides inside. He becomes lifeless and unnoticed, separated from the green leaves of society. The handicapped people need to be given the chance to break open their cocoons and begin life again. Full opportunity employment can give them this chance.

Jerry Cook was given her opportunity. She broke her cocoon wide open when she began work at Hughes Aircraft Company. She works as an accountant, and even though she has

only one arm, she types 45 words per minute. When she is not working, Jerry is teaching her copyrighted typing system to similarly handicapped people in the ghetto.¹

Harry Rath was not so fortunate. With one leg missing at the knee, he applied for the job he had been experienced in before his disabling injury — that of truck driver. Despite evidence that men with one leg can perform truck driver duties with skill and safety, Harry was turned down. The trucking company manager felt customers would object to entrusting their goods to a one-legged driver. Instead of breaking out of his cocoon, Harry Rath just curled up inside of it.²

The handicapped are people who are fully capable of work despite their mental or physical disabilities. They are willing workers, but are often deprived of their opportunity by misunderstanding and bias.

There is much more unemployment among the handicapped than there should be. One reason is that they need more training and preparation for a job. Another reason is that many have just given up hope of finding a job. Some have become so discouraged that they have dropped from the labor market and are not even counted among the unemployed any more. The main reason, however, is America's attitude toward the handicapped and its acceptance of them. To illustrate just how much acceptance the handicapped people do have, the Roper Research Associates surveyed one thousand adults across the Nation. The people

surveyed were shown three case histories, the first concerning a mildly retarded young man, the second a blind youth, and the third a young man crippled by a birth defect. The people were then asked what should be done about them. Half the people favored institutionalizing the retarded man. Over one-third favored institutionalizing the blind man, and over one-fifth gave the same response for the crippled man. Fifty-eight percent of the people thought sheltered employment should be allowed for the retarded man. Forty-five percent favored sheltered employment for the blind man, and thirty-nine percent for the crippled man. Only sixteen percent believed the retarded man should be permitted to work with others at a regular job. Forty-four percent favored this for the blind man, and thirty-six for the crippled man.³

Throughout all these answers lies one word: rejection. Just as people turn away from the sight of a caterpillar, they also turn away from the handicapped. America does not understand the handicapped. Every unemployed handicapped represents dashed hopes, despair, discouragement, frustration. For years, these people have been denied jobs because of misunderstanding, but America is finally beginning to wake up to their abilities and usefulness.

The trends toward automation and specialization in industry today are opening up new working fields for the handicapped. A highly

trained computer engineer, for example, performs his vital job perfectly well at Hughes Aircraft Company, though he has been almost totally paralyzed by polio for five years.⁴

A large Chicago insurance company has found that deaf mutes make better-than-average file clerks and checkers. They are able to concentrate better because they are not affected by office noise and distractions. Other deaf people have learned to work as linotype, tabulator, and key-punch operators. Blind workers, with their sense of touch highly developed because of their loss of sight, have made superior assemblers, inspectors, sorters, and counters of small objects in such vital industries as electronics and aircraft and missile production. Even cerebral palsy victims have been trained to use precise hand tools and work productively on assembly lines.⁵

These new fields are giving handicapped people a chance to prove to themselves and to America that they *can do it*. They have always been willing to break out of their almost unbearable cocoon. Given the opportunity of full employment, the handicapped, too, can emerge from their cocoon and become beautiful butterflies in today's society. □

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SEVENTH ANNUAL ARKANSAS-OKLAHOMA CANCER FORUM

September 25th-26th, 1975
Fort Smith, Arkansas

This one and one-half day meeting will be held at the Sheraton Inn in Fort Smith, September 25th-26th, 1975.

Guest speakers from Memorial Hospital, New York City and the Sloan Kettering Institute will highlight the program.

Further details to be announced later.

SANATORIUM CLOSES. GENERAL HOSPITALS TO CARE FOR TUBERCULOSIS PATIENTS

Oklahoma's last tuberculosis sanatorium, located at Talihina, became an Oklahoma Veterans Center on July 1st, 1975. In the future, a few tuberculosis patients requiring hospitalization will be admitted to one of four general hospitals. (Tuberculosis is now largely treated on an outpatient basis. When hospitalization is required, it is usually because of some associated non-tuberculous condition.) Designated physicians on the staffs of these hospitals will provide the medical care. Payment for services will be made through a state TB payment plan administered by the Division of Tuberculosis and Respiratory Diseases of the State Department of Health. This plan will provide funds for hospitalization and medical care, less any insurance or third party payments.

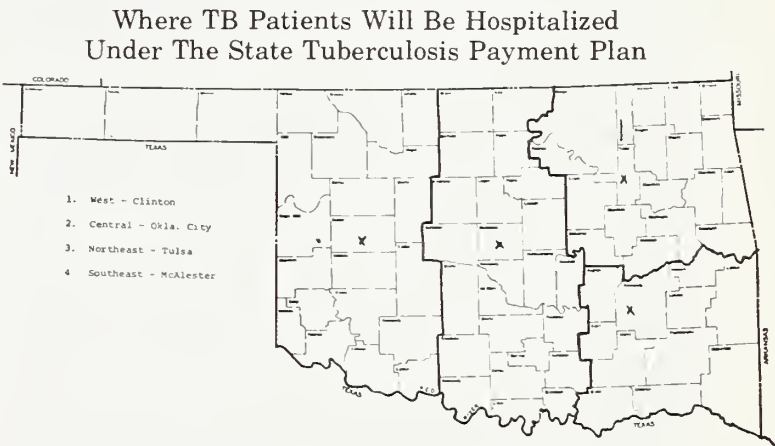
Physicians' requests for patient admission are to be made by telephone to the Director of the Tuberculosis and Respiratory Disease Division, State Department of Health, Oklahoma City, Oklahoma, Area Code 405, 271-4063. To be eligible for admission, the patient should



News From The Oklahoma State Department of Health

have a diagnosis of active tuberculosis. Patients with atypical mycobacteriological disease are not eligible for hospitalization under this plan.

The accompanying map shows the location of designated hospitals and the areas each serves for TB patients requiring hospitalization under the state payment plan. □



COMMUNICABLE DISEASES IN OKLAHOMA FOR MAY, 1975

DISEASE	May	May	April	Total To Date	
	1975	1974	1975	1975	1974
Amebiasis	2	1	1	6	7
Brucellosis	1	—	—	3	2
Chickenpox	213	167	159	887	695
Encephalitis, Infectious	1	2	2	14	15
Gonorrhea (Use Form ODH-228)	940	938	1104	5009	4323
Hepatitis, A, B, Unspecified	54	98	60	370	487
Leptospirosis	—	—	—	—	—
Malaria	—	—	—	1	1
Meningococcal Infections	—	—	1	8	11
Meningitis, Aseptic	4	6	1	13	20
Mumps	51	52	24	131	308
Rabies in Animals	11	14	8	58	64
Rheumatic Fever	1	4	4	6	7
Rocky Mountain Spotted Fever	21	7	3	25	10
Rubella	14	6	10	80	29
Rubella, Congenital Syndrome	—	—	—	1	1
Rubeola	72	6	3	90	19
Salmonellosis	16	45	6	68	107
Shigellosis	7	15	9	155	56
Syphilis, Infectious (Use Form ODH-228)	2	12	7	38	70
Tetanus	—	—	—	—	—
Tuberculosis, New Active	28	24	22	138	119
Tularemia	3	1	—	3	3
Typhoid Fever	—	—	—	—	—
Whooping Cough	1	1	8	12	6

For Consultation Call: (405) 271-4060

OSMA Public Relations Program Underway

Under the leadership of the association's Public Policy Council, a public relations program designed to inform Oklahomans about the deleterious affect of the new utilization review regulations, and other eminent federal activities, is underway.

Arnold G. Nelson, MD, the association's President just barely had time to name the council and its chairman, Joe Crosthwait, MD, before it went to work. Its initial activity centered around the utilization review regulations that were published on November 29th, 1974, by the Secretary of HEW, Caspar Weinberger.

Initially, the OSMA had taken a position of attempting to help hospitals implement the utilization review regulations. In January the Board of Trustees authorized the association's Foundation For Peer Review to publish a manual containing admitting criteria, standards and information regarding length of stay, to be distributed to all hospitals in the state. In addition, the association was instrumental in the formation of a Utilization Review Task Force made up of all parties concerned with the implementation of the new regulations: The Oklahoma Hospital Association, Osteopathic Association, Nursing Home Association, Oklahoma Health Department Hospital Licensing Section, State Welfare Department, and the Part A and Part B Medicare Carriers.

This Task Force conducted a series of seminars throughout the state to assist hospitals in implementing the regulations, if possible. It quickly became obvious that many hospitals would not be able to implement the regulations at all, and could possibly lose their Medicare reimbursements.

In February, the AMA filed a lawsuit in the Federal District Court of the Northern District of Illinois attacking the constitutionality of the regulations as published. At the same time, a ground swell of opposition to the regulations began to develop that ultimately cumulated in

a resolution being adopted by the OSMA House of Delegates at its annual meeting on April 25th.

That resolution stated, "that the physicians of the state of Oklahoma will continue utilization review and peer review on an individual hospital basis, and *will not participate in utilization review as outlined in the (November 29th) cited regulations . . .*"

That resolution called for the association to organize a public information campaign and authorize the association's Board of Trustees to institute a voluntary assessment to establish an adequate budget for such a campaign. Each member of the state medical association was asked to contribute \$100. As of mid-June, nearly \$40,000 had been voluntarily contributed.

Immediately after the OSMA House of Delegates annual meeting the association's Council on Public Policy employed a public relations firm from Tulsa to prepare the necessary public relations campaign material. This same firm, Schnake and Associates, Inc., had handled the association's Oklahoma University Health Sciences Center Campaign in 1974.

Under the guidance of Joe Crosthwait, MD, council chairman, the aim of the PR campaign was to generate at least 100,000 letters to President Gerald Ford urging him to have the Secretary of HEW withdraw the utilization review regulations. Officially the campaign was to begin on June 13th, with a press conference in Oklahoma City and Tulsa. The campaign was to center around a series of newspaper ads to appear in every state daily newspaper during the week of June 15th. The headline, in one and one-half inch type, was to read "WARNING! A NEW FEDERAL REGULATION MAY BE DANGEROUS TO YOUR HEALTH." This was to be followed by large-type copy, easily read, explaining that HEW was attempting to ration medical care to Medicare and Medicaid

recipients by instituting a plan of cost control under the guise of "quality" control.

The campaign did not start on June 13th. Instead, Judge Julius Hoffman of the Federal District Court in Illinois issued a preliminary injunction instructing the Secretary of HEW not to enforce the new regulations. OSMA leadership decided to take a "wait and see" attitude before launching its PR campaign. In the meantime, however, it continued to gear up in case it became necessary to go to the public.

While the judge's ruling was only "round one" in what could be a lengthy legal battle by the American Medical Association to defeat the utilization review regulations, it was a victory. Until there is a final ruling in the case, or until a higher court overturns Judge Hoffman's preliminary injunction, hospitals throughout the nation will operate under the old utilization review regulations.

While the Public Policy Council was gearing up for a public relations campaign, it was not ignoring another approach to the utilization review problem, *ie* the creation of a peer review plan that would meet the requirements of the law and that would be acceptable to Oklahoma physicians.

Through its Executive Committee the Council worked up a number of model peer review plans that might meet the qualifications for utilization review under the federal law, not necessarily those specified in the regulations.

The idea for a uniform plan, one that would be adaptable by any hospital in the state, came out of a trip to Washington, DC, by representatives from the council. Senator Henry Bellmon, acting as liaison, established a meeting between some top HEW officials and Doctors Joe Crosthwait, Kent Braden, Ken Whittington, and Arnold Nelson.

The idea for a uniform plan was brought back to Oklahoma for possible implementation. The OSMA staff was instructed to attempt to draw up such a plan in consultation with the various organizations that would be affected by it. The uniform plan that came out of this effort was a result of many consultations followed by rewrites.

It was originally thought that when the plan was finally perfected it would be taken back to Washington and presented to the Secretary of HEW. If the Secretary accepted the plan, it would then be published and distributed to all hospitals and physicians in the state for implementation in their local areas. If the Secretary rejected the plan, this rejection would be-

come a portion of the public relations campaign to show that he had placed himself in an inflexible position and was unwilling to compromise.

Since the ruling by the federal judge, all activities in regard to utilization review are being held in abeyance. The public relations campaign is ready, and the uniform plan is in its final stages of completion. If necessary, either or both of these activities can be restarted at a moment's notice.

In the meantime, the Public Policy Council has taken on another activity. A portion of Public Law 92-603, the Social Security Amendments of 1972, specifies that there is to be a ceiling on physicians' fees paid under Medicare based on physicians' charges for calendar year 1971 plus an increase related to an "economic index."

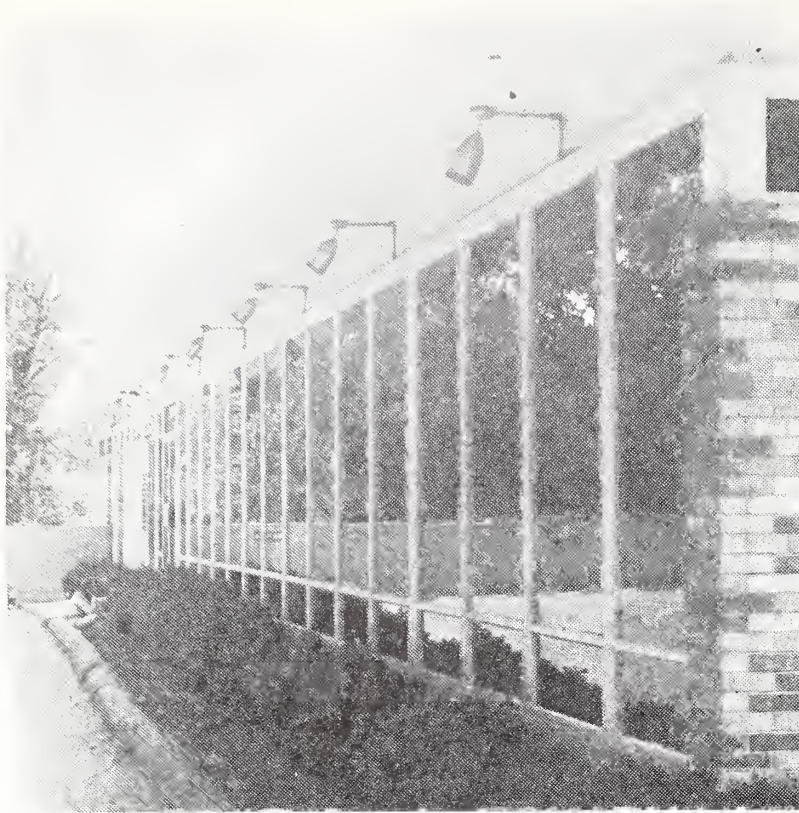
The implementing regulations on this section of the law will result in a rollback of physicians' allowable fees to the 1969 level. Although the law states "1971," the charged data in the Medicare computers for that year was based on physicians' charges in 1969.

The net result of this rollback will be that patient-beneficiary will see their Medicare reimbursement checks cut and there will be a greater discrepancy between the amount physicians are currently charging and the amount Medicare is recognizing as "allowable."

The Secretary of HEW has announced that he will allow a maximum of 17.93 percent increase over fees being charged in 1971. It is estimated that fully 80 percent of all current charges being recognized by Medicare and Medicaid would be reduced.

L. E. Rader, Director of the Oklahoma Welfare Department, objected to the new regulations and stated, "as proposed (they) would result in significant, widespread reductions of allowable charges below the current allowable charges. On unassigned claims, this will result in reduced payments to beneficiaries and could result in a sharp decrease in assignments. Many beneficiaries will be asking why Medicare is paying lower allowable charges than previously."

The association's Public Policy Council is in the process of drawing up a folder or brochure to be placed in every physicians' office in the state explaining the reimbursement rollbacks to Medicare patients. These brochures would be made available at cost to physicians for distribution to all of their Medicare and Medicaid patients. □



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Weinberger Responds to Nelson Letter

HEW Secretary Caspar Weinberger has personally responded to a letter from OSMA President, Arnold Nelson, MD, requesting that the utilization review regulations published on November 29th, 1974, be withdrawn.

In his response the Secretary commented on each of four primary reasons given by Doctor Nelson for the withdrawal. In the following transcript of that letter, the sections set off by alphabetized designations are the reasons stated by Doctor Nelson.

Following each such designated statement is Secretary Weinberger's response.

"(a) As many as 50 rural Oklahoma hospitals that neither have the medical staff nor the personnel to comply with the regulations would close.

"This problem is being addressed and resolved through technical assistance provided by our Dallas Regional Office to representatives of rural hospitals in Oklahoma. Utilization review committees are being formed in compliance with the third alternative of Section 405.1035(e) of the Medicare regulations . . . 'by a group established and organized in a manner approved by the Secretary that is capable of performing such function (utilization review).' This alternative was provided in the regulations to accommodate facilities that do not have an in-house capability to perform review functions. The alternative allows utilization review committees to be composed of eligible personnel from outside the facility. Such committees may perform utilization reviews for several hospitals.

"(b) The regulations violate the right of physicians to determine the medical treatment considered best for their patients.

"The regulations require the use of norms, criteria, and standards that physicians either developed or selected for use by the utilization review committee in reviewing the necessity for admissions and continued stays and conducting medical care evaluation studies. These norms, criteria, and standards, however, are to be used only as screening mechanisms. When admissions or continued stays do not fall within the screening, the attending physician is afforded an opportunity to provide justification for such. The attending physician's views and decisions may only be disallowed by at least two concurring physician members of the Utilization Review Committee. This procedure

should enhance the attending physician's determination of medical treatment rather than violate his right to make such determinations.

"(c) For Medicare and Medicaid patients, the regulations will result in many medical decisions being made by people not licensed to practice medicine.

"Only physician members of the Utilization Review Committee are allowed to make medical decisions. A trained review coordinator, using physician-developed or selected norms, criteria, and standards, will screen cases against the physician-developed data. Cases not passing the screen will be automatically referred to a physician committee member for further evaluation and preliminary medical determination. As stated above, no final adverse medical decisions will be made before consulting the attending physician.

"(d) Implementation of the regulations will place constraints not legislated by Congress upon benefits promised to Medicare and Medicaid recipients.

"Congressional legislation was predicated on the conviction that beneficiaries of federal programs deserve the best possible health care and that every federal health care dollar should be wisely spent. The regulations were developed with that mandate in mind and will afford hospitals and other providers an efficient model for quality assurance."

In closing his letter, Secretary Weinberger stated, "we continue to support the concept of the utilization review regulations. As you may know, the US District Court of Northern Illinois has issued a preliminary injunction against the implementation of the Utilization Review Regulations. The department is currently studying that injunction order to determine what further steps are necessary." □

Remember These Dates -

MAY 5th, 6th, 7th, 8th, 1976

Oklahoma Medical Summit '76

A combined meeting of the Oklahoma State Medical Association, the Oklahoma City Clinical Society and the Oklahoma Academy of Family Physicians.

Putnam City High School Teacher Receives OSMA Award



Mrs. Pat Lukehart, center above, is shown as S. N. Stone, MD, Speaker of the OSMA House of Delegates presents her with a check for a \$250 expense-paid trip to Washington, D.C. Also attending the presentation was John Harris, Advice Chairman of the Governor's Committee on Employment of the Handicapped.

The award presentation was held March 26th, 1975, at 1:00 p.m., in the Second floor Conference Room of the State Capitol in Oklahoma City.

Each year the OSMA sponsors the trip for the teacher of the essay winner of the "Ability Counts" contest which is sponsored by the Governor's Committee on Employment of the Handicapped. This year's winner was Cindy Miller, Putnam City High School student, and her winning paper is printed on page 225 of this issue of *The Journal*. □

Life Certificates Awarded Three Tulsa Physicians



During a quarterly meeting of the Tulsa County Medical Society, three Tulsa physicians were awarded Life Membership Certificates by the Oklahoma State Medical Association. The ceremonies were held May 12th, 1975, at the Children's Medical Center in Tulsa.

Pictured (left to right) are Jack L. Richardson, MD, immediate Past-President of the OSMA, shown making the presentations; Felix O. Durham, MD, Francis W. Pruitt, MD, and James G. Moore, MD.

Doctor Durham has practiced psychiatry in Tulsa since 1973 and previously was in practice in New York City.

Doctor Pruitt came to Tulsa in 1959 following his retirement as a Brigadier-General in the US Army during which time he served as a personal physician to General Dwight D. Eisenhower. His specialty is internal medicine.

Also retiring as a Brigadier-General in the US Army in 1962, Doctor Moore practiced in Tulsa until his retirement two years ago. He practiced general preventive medicine and occupational medicine. □

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Proceedings of the 69th Annual Session of the House of Delegates of the Oklahoma State Medical Association

OPENING SESSION

I. CALL TO ORDER:

The House of Delegates convened its 69th Annual Session in the Lincoln Plaza Inn, Oklahoma City, Oklahoma, on April 23, 1975. The Speaker, S. N. Stone, MD, Oklahoma City, called the meeting to order at 2:50 p.m.

II. INVOCATION:

John A. Blaschke, MD, Oklahoma City, delivered the invocation.

III. REPORT OF THE CREDENTIALS COMMITTEE:

The presence of a quorum was reported by Jack D. Fetzer, MD, Chairman, Woodward.

IV. APPOINTMENT OF COMMITTEES OF THE HOUSE:

Doctor Stone announced the appointment of the following committees to assist in the conduct of the meeting:

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William G. Bernhardt, MD, Midwest City
Edward W. Allensworth, MD, Vinita
Carl H. Guild, MD, Bartlesville
Joe B. Jarman, MD, Enid
Jack D. Honaker, MD, Frederick
Lynwood Heaver, MD, Tulsa
T. C. Alexander, MD, Okmulgee

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Henry Wolfe, MD, Hugo
Clarence P. Taylor, MD, Ada
Billy Dale Dotter, MD, Okeene
William Z. Cook, Jr., MD, Stilwell
William M. Benzing, Jr., MD, Tulsa
Yale E. Parkhurst, MD, Miami
M. R. Jennings, MD, Claremore

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Harlan Thomas, MD, Tulsa
Casey Truett, MD, Norman

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Charles Tefertiller, MD, Altus
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A. C. Roberson, MD, Anadarko
David D. Rose, MD, Ardmore
Charles W. Cathey, MD, Oklahoma City
Fred R. Martin, MD, Tulsa
Ed Kelsay, Staff

V. INTRODUCTION OF SPECIAL GUESTS:

Mrs. John W. Williams, Retiring President of the Woman's Auxiliary to the Oklahoma State Medical Association was introduced and brought greetings to the OSMA House of Delegates.

Mrs. William B. Renfrow, Incoming President of the Woman's Auxiliary to the Oklahoma State Medical Association, and Doctor Malcolm Todd, President of the American Medical Association, were introduced. Doctor

(Continued on Page 243)

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NELSON NAMES COUNCILS AND COMMITTEES

Arnold G. Nelson, MD, President of the Oklahoma State Medical Association, has released a tentative list of his appointments.

Standing committees and councils are

established in the OSMA Bylaws, while special committees are designated by the President to carry out specific functions under the jurisdiction of appropriate councils.

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**Arkansas-Oklahoma Cancer Forum
Will Convene in September**

The Annual Arkansas-Oklahoma Cancer Forum will be held at the Sheraton Inn in Fort Smith, Arkansas, September 25th-26th, 1975. The day and a half program has been developed in cooperation with the Memorial Hospital and Sloan Kettering Institute of New York City.

A complete program follows:

**CURRENT CONCEPTS IN CARE
OF THE CANCER PATIENT**

Morning Session: Thursday, September 25th, 1975

Chairman: Frank H. McGregor, MD, President, Oklahoma Division, Inc., American Cancer Society, Oklahoma City

8:25—8:30 Welcome and Opening Remarks
— Frank H. McGregor, MD

8:30—9:10 **THE CLINICAL ROLE OF THE
PATHOLOGIST IN THE MANAGE-
MENT OF PATIENTS WITH CANCER**
Paul Rosen, MD, Associate Attending
Pathologist, Department of Pathology,
Memorial Sloan-Kettering Cancer
Center, New York City

9:10—9:50 **MANAGEMENT OF BENIGN
LESIONS OF THE LOWER GI TRACT**
Stuart Quan, MD, Associate Attending
Surgeon, Rectal and Colon Service, De-
partment of Surgery, Memorial Sloan-
Kettering Cancer Center, New York City

9:50—10:05 Intermission

10:05—10:45 **PRACTICAL MANAGEMENT
OF PATIENTS WITH OVARIAN CAR-
CINOMA**

James H. Freel, MD, Assistant Attending
Surgeon, Gynecology Service, Depart-
ment of Surgery, Memorial Sloan-
Kettering Cancer Center, New York City

10:45—11:25 **WHAT'S BEST FOR THE PA-
TIENT**

Charles Kelley, MD, Assistant Attending
Radiation Therapist, Department of
Radiation Therapy, Memorial Sloan-
Kettering Cancer Center, New York City

11:25—12:05 **PSYCHIATRIC SUPPORT OF
THE CANCER PATIENT**

Fred O. Henker, MD, Associate Professor
of Psychiatry, University of Arkansas
Medical Center, Little Rock

Afternoon Session: Thursday, September 25th,
1975

Chairman: Fred Caldwell, MD, President, Ar-
kansas Division, Inc., American Cancer
Society, Little Rock, Arkansas

1:30—2:10 **RESULTS OF BREAST
SCREENING IN OKLAHOMA**

JoAnn Haberman, MD, PhD, Director of
Oklahoma Breast Screening Project and
Associate Professor, Department of
Radiology, University Health Sciences
Center, Oklahoma City

2:10—2:50 **SPECIMEN RADIOGRAPHY IN
BREAST CANCER**

Paul Rosen, MD

2:50—3:30 **RATIONALE FOR MANAGE-
MENT OF PATIENTS WITH POTEN-
Tially CURABLE BREAST CANCER**

Guy F. Robbins, MD, Attending Surgeon,
Breast Service Department of Surgery,
Memorial Sloan-Kettering Cancer
Center, New York City

3:30—3:45 Intermission

3:45—4:25 **PRACTICAL MANAGEMENT
OF PATIENTS WITH ENDOMETRIAL
CARCINOMA**

James H. Freel, MD

4:25—5:05 **IMMUNI-THERAPY IN PEDI-
ATRIC PATIENTS WITH MALIGNAN-
CIES**

G. Bennett Humphrey, MD, Chief
Hematology-Oncology Service, Oklahoma
Children's Memorial Hospital, Associate
Professor, Department of Pediatrics, Uni-
versity of Oklahoma Health Sciences
Center

Morning Session: Friday, September 26th,
1975

Chairman: Robert Janes, MD, President,
Sebastian County Unit, American Cancer
Society, Arkansas

9:00—9:40 MANAGEMENT OF MALIGNANT LESIONS OF THE LOWER GI TRACT
 Stuart Quan, MD

9:40—10:20 WHAT'S NEW IN RADIATION THERAPY
 Charles Kelley, MD

10:20—10:35 Intermission

10:35—11:15 WHAT'S NEW IN CANCER CHEMOTHERAPY
 Richard H. Bottomley, MD, Head Oncology Division, Department of Medicine, University Hospital, University of Oklahoma Health Sciences Center

11:15—11:55 READAPTATION OF CANCER PATIENTS TO SOCIETY
 Guy F. Robbins, MD

11:55 Adjournment

There is no registration fee for the meeting. All members of the medical profession, registered nurses and medical students are urged to attend this informative session. Category 1 credit will be offered by the American Medical Association and the prescribed credit offered by the American Academy of Family Practice. □

DEATH

JOEL S. PRICE, MD
 1902-1975

A longtime Oklahoma City surgeon, Joel S. Price, MD, died June 14th, 1975. Born in Dewey County, Oklahoma, Doctor Price was graduated from the University of Oklahoma College of Medicine in 1928. He practiced in Oklahoma City for forty years before his retirement in 1967. Doctor Price was a member of the Oklahoma Academy of Family Practice and a member of the Phi Chi medical fraternity. □

Oklahoma Physicians Tagged For Neurosurgical Society Offices

Two Oklahoma physicians have been named to office in the Rocky Mountain Neurosurgical Society for 1975-76. They are Robert L. Imler, MD, Tulsa as President and Alvin Rix, MD, Oklahoma City as Vice-President. □



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FOR SALE: NEW TEN ROOM CLINIC; two doctors. Fully equipped, 200 M.A. x-ray, lab, E.C.G. Large waiting room, concrete parking lot. Hospital privileges. Henryetta. Reason for sale, returning for residency training. Contact Key H, *The Journal*, Oklahoma State Medical Association, 601 N.W. Expressway, Oklahoma City, Oklahoma 73118.

INTERNIST NEEDED for eight-doctor multi-specialty group in Ardmore. This is an excellent opportunity in a city of 23,000 people, ideally located 100 miles south of Oklahoma City and 100 miles north of Dallas. Excellent clinic and hospital facilities. Ardmore has an ideal combination of industry, farming and ranching, and oil. Ideal recreation facilities are available at Lake Murray, ten miles from Ardmore. Available July 1st, 1975. C. L. Lorentzen, MD, Medical Arts Clinic, 921 14th, NW, Ardmore, Oklahoma 73401.

CLAREMORE, 20 MILES NORTHEAST OF TULSA in the heart of Green Country, is in need of family physicians and internists. Office space is available within one block of a newly expanded 105-bed, fully accredited hospital. This progressive medical community is highly desirous of attracting new physicians as soon as possible. Interested parties should contact Larry I. Young, MD, Drawer B, Claremore, Oklahoma 74017, 918 341-5311.

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GP SURGEON, Diplomate American Board of Family Physicians, wants practice in town under 15,000. Wants group or share expense or solo with trade calls and time off. Contact Key F, *The Journal*, Oklahoma State Medical Association, 601 N.W. Expressway, Oklahoma City 73118. ☐

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OKLAHOMA STATE MEDICAL ASSOCIATION

This booklet was prepared by the staff of the OSMA in 1969 and was published by the Insurance Company of North America for distribution to all medical doctors in the state. It has now been republished and is available upon request.

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Stone stated that Doctor Todd would be speaking to the delegates later on in the program.

VI. PRESENTATIONS:

A. Doctor Don H. O'Donoghue, presented the A. H. Robins Physician Award for Community Service to Doctor Harry Wilkins, Oklahoma City.

B. Doctor Arnold G. Nelson, OSMA President-Elect presented an AMA-ERF check in the amount of \$17,648.38 to Doctor Tom Lynn, Dean of the OU College of Medicine.

Doctor Lynn expressed gratitude on behalf of the OU Health Sciences Center.

VII. REMARKS OF THE SPEAKER:

Doctor Stone introduced Betty Lyles and Suzanne Wilson as the transcribing secretaries.

VIII. REPORT OF THE PRESIDENT:

Doctor Jack L. Richardson presented his report and it was referred to Reference Committee No. I. (A copy of the report is attached and made a part of these minutes).

IX. REPORT OF THE PRESIDENT-ELECT:

Doctor Arnold G. Nelson presented his report and it was referred to Reference Committee No. I. (A copy of the report is attached and made a part of these minutes).

X. REPORT OF THE CHAIRMAN OF THE BOARD:

Doctor John McIntyre presented information contained in the Board of Trustees Report and the Board's Supplemental Report. Both reports were referred to Reference Committee No. I. (Copies of the reports are attached and made a part of these minutes).

XI. SECRETARY-TREASURER'S REPORT:

Doctor Stone stated that this report will be deferred until the Closing Session of the House of Delegates. The Secretary-Treasurer's Report was referred to Reference Committee No. I. (A copy of the report is attached and made a part of these minutes).

XII. NOMINATIONS FOR ELECTIONS:

Doctor Stone announced the House would recess for ten minutes for all Trustee Districts XI, XII, XIII and XIV to caucus.

XIII. NOMINATIONS:

The House was declared open for the nominations for the position of PRESIDENT-ELECT (One year term of office).

Orange M. Welborn, MD, Ada, was nominated by *David Ramsay, MD*, Ada.

Roger J. Reid, MD, Ardmore, was nominated by *Frank W. Clark, MD*, Ardmore.

Nominations were declared closed.

Nominations were declared open for the position of VICE-PRESIDENT (One year term of office).

William M. Leebron, MD, Elk City, was nominated by *Ed Calhoon, MD*, Beaver.

Nominations were declared closed.

Nominations were declared open for the position of SECRETARY-TREASURER (Two year term of office).

Haven W. Mankin, MD, Oklahoma City, was nominated by *Roger Reid, MD*, Ardmore.

Nominations were declared closed.

Nominations were declared open for the position of DELEGATE TO THE AMA (Two year term of office).

Ed L. Calhoon, MD, Beaver, was nominated by *John X. Blender, MD*, Cherokee.

Nominations were declared closed.

Nominations were declared open for the position of ALTERNATE DELEGATE TO THE AMA. (Two year term of office).

M. Joe Crosthwait, MD, Midwest City, was nominated by *Kent Braden, MD*, Oklahoma City.

Nominations were declared closed.

Nominations were declared open for TRUSTEE AND ALTERNATE TRUSTEE for the following Trustee Districts (three year term of office):

DISTRICT XI:

Reporting on the caucus of representatives from District XI, the following nominations were made:

Beryl R. McCann, MD, Durant, was nominated for the position of Trustee.

Thomas E. Rhea, MD, Idabel, was nominated for the position of Alternate Trustee.

DISTRICT XII:

Orange M. Welborn, MD, Ada, nominated *Frank W. Clark, MD*, Ardmore, for the position of Trustee.

Clarence P. Taylor, MD, Ada, was nominated for the position of Alternate Trustee.

DISTRICT XIII:

Samuel Jack, MD, Lawton, nominated *Paul N. Vann, MD*, Lawton, for the position of Trustee.

A. C. Roberson, MD, Anadarko, was nominated for the position of Alternate Trustee.

DISTRICT XIV:

Fred W. Sellers, MD, Mangum, nominated *Lowell N. Templer, MD*, Altus, for the position of Trustee.

Fred W. Sellers, MD, Mangum, was nominated for the position of Alternate Trustee.

XIV. ADDRESS FROM THE PRESIDENT OF THE AMERICAN MEDICAL ASSOCIATION:

Doctor Malcolm Todd, President of the American Medical Association, addressed the House of Delegates and brought greetings. He stated that each physician should and must preserve the private practice of medicine in the United States of America.

Doctor Todd stated that the AMA has several legal actions in progress at the present time. Some of the actions include health planning bills, actions on federal regulations regarding utilization review, those involving the Anti-Substitution Bill on drugs, etc.

Doctor Todd expressed his appreciation to the Oklahoma physicians for their unified membership support in previous years.

Doctor Jack L. Richardson presented a plaque of appreciation to Doctor Todd on behalf of the Oklahoma State Medical Association.

XV. INTRODUCTION OF COUNCIL AND COMMITTEE REPORTS AND RESOLUTIONS:

Doctor Stone advised the Delegates that in order to save time, a list of reports and resolutions is included in their portfolios, and an item by item introduction would not be necessary. Doctor Stone also advised the Delegates that "late resolutions" have been approved for introduction by the Board of Trustees in accordance with the Bylaws.

XVI. ANNOUNCEMENT:

Doctor Stone stated that the reference committee hearings will be held at 8:00 a.m., April 24th.

XVII. NECROLOGY REPORT:

The Vice-Speaker of the House of Delegates, Jack Fetzner, MD, read the Necrology Report. (A copy of the report is attached and made a part of the minutes).

XVIII. ADJOURNMENT OF OPENING SESSION:

The Opening Session of the House of Delegates was adjourned at 5:00 p.m.

NECROLOGY REPORT

Alfred T. Baker, MD, Durant
James C. Brogden, MD, Tulsa
Elizabeth M. Chamberlin, MD, Bartlesville
James B. Eskridge, Jr., MD, Oklahoma City
Emry G. Hyatt, MD, Tulsa
William A. Hyde, MD, Durant

Emery W. King, MD, Bristow
Robert L. Loy, MD, Oklahoma City
Thomas J. McGrath, MD, Sayre
George H. Miller, MD, Tulsa
Charles J. Roberts, MD, Enid
Mary V. S. Sheppard, MD, Oklahoma City
Harlan K. Sowell, MD, Oklahoma City
C. Riley Strong, MD, El Reno
Noble F. Wynn, MD, Edmond

CLOSING SESSION

I. CALL TO ORDER:

The Closing Session of the 69th Annual Meeting of the House of Delegates was called to order by the Speaker, S. N. Stone, MD, at 9:15 a.m., April 25, 1975, in the Lincoln Plaza Inn, Oklahoma City.

II. REPORT OF THE CREDENTIALS COMMITTEE:

Jack D. Fetzner, MD, Chairman of the Credentials Committee, announced a quorum present.

III. INVOCATION:

Rex Kenyon, MD, Oklahoma City, delivered the invocation.

IV. INTRODUCTION OF SPECIAL GUESTS:

Doctor Stone introduced Mrs. James Manning from Marietta, Georgia, President of the Woman's Auxiliary to the Southern Medical Association and Mrs. Erle E. Wilkinson from Nashville, Tennessee, President-Elect of the Woman's Auxiliary to the AMA. Both brought greetings to the OSMA House of Delegates.

V. REPORTS OF REFERENCE COMMITTEES:

All reports considered by the House of Delegates are attached and approved and made a part of these minutes.

REPORT OF REFERENCE COMMITTEE NO. III:

Presented by: Jack Parrish, MD, Seminole, Chairman

Mr. Speaker and Members of the House of Delegates, your reference committee gave careful consideration to the items referred to it and makes the following report:

Item I: Report of the Council on Socioeconomic Activities:

Mr. Speaker, your committee considered this report and wishes to commend the members of the council, and specifically the members of the OSMA Peer Review Committees, for their work and recommends that this report be adopted as written.

Mr. Speaker, I move the adoption of this report. The motion was seconded and it carried.

Item II: Report of the Council on Continuing Medical Education:

Mr. Speaker, your committee feels that it cannot overstate the importance of continuing medical education to the practice of medicine. The actions and activities of this council are to be commended.

Mr. Speaker, I move the adoption of this report as written. The motion was seconded and it carried.

Item III: Report of the Medical Center Liaison Committee:

Mr. Speaker, the activities of this committee during this past year deserve special consideration. The statewide public relations campaign launched to support the Oklahoma Health Sciences Center has resulted in a better understanding of the center's operation and its needs for support by the practicing medical community.

Recommendation No. 2 should be deleted from this report. Resolution No. 15, considered by Reference Committee No. II speaks to this issue.

Mr. Speaker, I move the adoption of this report as amended. The motion was seconded and it carried.

Item IV: Report of the Financial Aid to Education Committee:

Mr. Speaker, your committee recommends that the functions of this committee be more widely publicized to association members.

Mr. Speaker, I move the adoption of this report as written. The motion was seconded and it carried.

Item V: Report of the Council on Public Health:

Mr. Speaker, your reference committee wishes to commend the members of the council and the various committees of the council for their activities during the past year.

Mr. Speaker, I move the adoption of this report as written. The motion was seconded and it carried.

Item VI: Resolution No. 4:

Mr. Speaker, this resolution reiterates the recommendations made in the report of the Committee on Emergency Medical Services contained in the report of the Council on Public Health. Both the committee report and this resolution deserve the support of the OSMA.

Mr. Speaker, I move the adoption of this resolution. The motion was seconded and it carried.

Item VII: Resolutions No. 5, 10, and 13:

Mr. Speaker, your reference committee considered Resolutions No. 5, 10 and 13 together. It was felt that the subject matter of these three resolutions was compatible.

After carefully considering all of the testimony it received on Thursday morning, it is the recommendation of your committee that these three resolutions be replaced by the following substitute resolution:

WHEREAS, the published regulations appearing in the Federal Register on November 29, 1974 implementing Utilization Review are inconsistent with good patient care, infringe on the doctor-patient relationship, threaten the confidentiality of that relationship, promulgate the deterioration of quality medical care, pose the potential threat of closing many hospitals and threaten our patients with possible loss of hospital privileges and financial assistance, and

WHEREAS, Peer Review and Utilization Review has been traditionally performed by the profession to assure quality medical care, not cost control, and is best handled at the local level so that it can take into consideration local problems, and

WHEREAS, any nationwide method of Utilization Review must necessarily ignore such local problems and cannot be accurately varied into size of hospital facility or medical staff, and

WHEREAS, any such national scheme will result only in a rationing of health care services to patients, therefore be it

RESOLVED, that the physicians of the State of Oklahoma vigorously support the American Medical Association's lawsuit against these onerous regulations, and, therefore be it

RESOLVED, that the physicians of the State of Oklahoma will continue Utilization Review and Peer Review on an individual hospital basis, and will not participate in Utilization Review as outlined in the above cited regulations, and

WHEREAS, the Oklahoma State Medical Association recognizes that this stance will require a public relations campaign to inform the general public as to the necessity for this position, now therefore be it

RESOLVED, that the House of Delegates of the Oklahoma State Medical Association authorize the OSMA Board of Trustees to institute a voluntary assessment to establish an adequate public relations campaign budget in

the event that the Federal Court upholds the regulations as currently published, and therefore be it further

RESOLVED, that the Oklahoma State Medical Association seek the broadest possible base of support in such a campaign by contacting other medical associations throughout the United States.

Mr. Speaker, I move the adoption of this substitute resolution in place of Resolutions 5, 10 and 13. Doctor Carpenter seconded the motion.

The House was opened for discussion. Doctor Crosthwait made a motion that discussion on this topic be limited to three minutes. The motion was seconded and it carried.

After considerable discussion on this item, Doctor R. W. Goen, Tulsa, moved that the word "voluntary" be stricken from the first resolve and the word "mandatory" be put in its place. The motion was seconded.

An amendment was made to the motion that the mandatory assessment be not under \$50 per person.

After further discussion, Doctor Nelson called for the question on the amendment. Doctor McIntyre seconded the amendment.

The amendment for a mandatory assessment of not under \$50 was opposed.

Doctor James Eskridge requested that the reference committee consider editorial changes on page 3, paragraph 1 to read as follows:

"Whereas, the published regulations appearing in the Federal Register on November 29, 1974 implementing Utilization Review are inconsistent with good patient care, infringe on the doctor-patient relationship, constitute unsolicited and therefore unethical consultation, threaten the confidentiality of that relationship, promulgate the deterioration of quality medical care, pose the potential threat of closing many hospitals and threaten our patients with possible loss of hospital privileges and financial assistance, and . . .".

Doctor Berry, Kingfisher, made a motion that the last resolve be changed to read as follows:

"Resolved, that the Oklahoma State Medical Association seek the broadest possible base of support in such a campaign by inviting cooperation by other state medical associations throughout the United States."

Doctor Braden called for the question on the editorial change. The editorial change was seconded and carried.

The vote was called on the amendment made in the last resolve. The motion was seconded and it carried.

The question was called for the acceptance of the substitute motion. The motion was seconded and carried. There were two no votes.

Item No. VIII: Resolution No. 9:

Mr. Speaker, your committee feels that this resolution is a restatement of the association's current position. Mr. Speaker, I move the adoption of this resolution as written. The motion was seconded and carried.

Item No. IX: Resolution No. 11:

Mr. Speaker, it was the understanding of your committee that the American Medical Association is in the process of establishing an office similar to the one called for in Resolution No. 11. Until such time as that office is clarified and its functions delineated, your committee feels that any action in this regard by your state medical association should be postponed.

Mr. Speaker, I move that Resolution No. 11 be not adopted. The motion was seconded and it carried. There was one no vote.

Item No. X: Resolution No. 14:

Mr. Speaker, after carefully considering the testimony your committee received on this resolution, the committee came to the conclusion that perhaps it is not the ethics of the situation, but the Oklahoma law that should be changed. Therefore, your committee recommends that the section of the Oklahoma statute cited in this resolution be studied by appropriate legal counsel to see if such a change should be implemented.

Mr. Speaker, I move that Resolution No. 14 be not adopted.

Doctor Jack Parrish made a substitute motion and the resolve should read as follows:

"Resolved, that the Report of the Judicial Council of the AMA be waived until such time that the Oklahoma statute is changed or waived."

The motion was seconded and carried on the substitute motion.

Item No. XI: Resolution No. 16:

Mr. Speaker, your committee considered this resolution very carefully. While the committee admired the philosophy outlined in this resolution, the resolves it contains are so far reaching and encompass so many facets of the social, economic, and political aspects of the practice of medicine as to make it untenable in this form. Many of the resolves are being han-

dled specifically by the reports of the association's various councils, committees and other resolutions.

Your committee wishes to specifically commend Kent Braden, MD, for so eloquently outlining the philosophy that we all would like to espouse. However, an attempt to encompass it all in one omnibus resolution simply is unworkable.

Mr. Speaker, I move that Resolution No. 16 be not adopted. The motion was seconded and carried.

Mr. Speaker, I would like to extend my thanks to the reference committee and to those who came to give testimony. I would also like to thank Ed Kelsay and the staff.

Mr. Speaker, I move the adoption of this report as a whole. The motion was seconded and it carried.

The House of Delegates recessed for ten minutes.

REPORT OF REFERENCE COMMITTEE NO. II:

Presented by: Robert Shepard, MD, Tulsa, Chairman

Mr. Speaker and Members of the House of Delegates, Reference Committee No. II has carefully considered the items which were referred to it and submits the following report:

Item I. Report of the Council on Professional and Intervocational Relations:

Mr. Speaker, your Committee considered this report in its entirety and wishes to commend the Chairman and his committees for the fine effort expended on behalf of the Association. Members should recognize and be aware that cordial relations with others involved in medical care services are essential and beneficial to the Association.

RECOMMENDATION:

Mr. Speaker, we recommend approval of the Report of the Council on Professional and Intervocational Relations.

Mr. Speaker, I move the adoption of this portion of the Report. The motion was seconded and carried.

Item II: Report of the Council on Public Policy:

Mr. Speaker, your Committee considered this report in its entirety. We would like to make note of the report of the State Legislative Committee. Last year the Delegates approved a recommendation that the Association purchase or lease an automatic typewriter. As indicated in the report, the equipment is installed and has been of significant help to the com-

mittee and the Association in meeting its communication needs. The Delegates can take pride in the decision made last year. We also mention the fact that the committee has utilized the services of outside help in a special case when it was deemed necessary. Barton Carl, MD, Chairman of the Committee testified about the success of this approach and recommended that this technique be employed when necessary and approved by the Trustees.

RECOMMENDATION:

Mr. Speaker, we recommend approval of the Report of the Council on Public Policy.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item III: Resolutions No. 7 and 8:

Both Resolutions 7 and 8 deal with insurance companies and the policies they use to underwrite the risks they insure. Resolution No. 7 expresses concern over the retrospective review of patients' medical records after claims have been filed. Resolution No. 8 addresses itself to the problem of the "pre-existing illness" clause in insurance policies that results in the denial of some claims. Testimony cited the problems of patients who, after paying premiums for years, find that specific illnesses are not covered on the grounds of being "pre-existing." Your Reference Committee expresses concern over the less than honorable practices of some insurance companies but we recognize that certain information and investigations are necessary to the insurance industry. We suggest that Resolutions 7 and 8 be referred to the Council on Insurance with instructions to study these problems and make recommendations to the Board of Trustees for implementation, and that a progress report be made to the House next year.

RECOMMENDATION:

Mr. Speaker, we recommend that Resolutions 7 and 8 be referred to the Council on Insurance.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item No. IV: Resolution No. 15:

Resolution No. 15 requests that a Committee be appointed to study the admissions policy of the OU College of Medicine. The Committee was informed that a Senate Joint Resolution (SJR 22) has passed the Oklahoma Senate that would legislate the composition of the Board of Admissions. The Committee was also advised that authors of the bill have under consid-

eration amendments that would require membership of the Board of Admissions to represent each of the six congressional districts. Two physicians would be selected from each district. They would be appointed by the State Medical Association with concurrence of the local medical societies. Your Reference Committee listened to considerable testimony on this issue and feels that it is not in the best interest of the school for the Legislature to dictate the composition of the Admissions Board. However, it is obvious that a great number of physicians in the State, in addition to our political leaders and the lay public, do not understand the admissions policies of the OU College of Medicine. We feel that a comprehensive study with accompanying public relations and dissemination of information to the physicians of Oklahoma would be of great benefit to the school.

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends the adoption of Resolution 15. The motion was seconded and it carried.

Mr. Speaker, I recommend the adoption of this portion of the report. The motion was seconded and it carried.

Mr. Speaker, I recommend the adoption of Reference Committee Report No. II as a whole. The motion was seconded and it carried.

Robert M. Shepard, Jr., MD, Tulsa, Chairman

John A. Blaschke, MD, Oklahoma City

E. C. Yeary, MD, Ponca City

Frank Adelman, MD, Enid

Irwin H. Brown, MD, Oklahoma City

James S. Jones, MD, Duncan

George M. Brown, Jr., MD, McAlester

Samuel C. Jack, MD, Lawton

David Bickham, Staff

REPORT OF REFERENCE COMMITTEE NO. I

Presented by: Arthur F. Elliott, MD, Oklahoma City, Chairman

Mr. Speaker and Members of the House of Delegates, your reference committee gave careful consideration to the items referred to it and makes the following report:

Item I: Report of the President:

Your reference committee recommends adoption of the Report of the President, and commends Doctor Richardson for his efforts on behalf of the association during the past year.

Mr. Speaker, I move the adoption of this por-

tion of the report. The motion was seconded and it carried.

Item II: Report of the President-Elect:

Doctor Arnold G. Nelson, incoming president of the association, set a worthy precedent by addressing the House of Delegates, a practice which your reference committee hopes will be continued in future years. Doctor Nelson made two recommendations in his report, and requested delegates' action, as follows:

Recommendation No. 1:

"I would like to recommend that our House of Delegates approve upcoming meetings of the Oklahoma Medical Summit in Oklahoma City for at least the next three years. Many times, on the short notice we have had, it is somewhat difficult to obtain some of the speakers and some of the commitments that we could have otherwise had, had we had a longer notice."

Recommendation No. II:

"I recommend that your new president be allowed to appoint an Ad Hoc Committee to study the committee structure of our association, and that the Ad Hoc Committee be chaired by the new president-elect whoever he may be. Councils and committees should be studied and defined."

Your reference committee concurs in both of the preceding recommendations, and recommends their adoption by the House of Delegates. It is clear that physical arrangements for medical conventions need to be made well in advance, and that prominent scientific lecturers cannot be obtained on short notice. Secondly, during this dynamic era of change, which can have significant impact on medical practice, it is imperative that the OSMA continually assess its priorities and devote its financial and personnel support to those committee activities which have the greatest import. An assessment of our committee structure is certainly in order, and Doctor Nelson shows wisdom in recognizing this need.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item III: Report of the Secretary-Treasurer:

The Secretary-Treasurer has presented to the House a forthright assessment of the economic condition of the OSMA, and has observed that present annual dues of \$120 annually will not likely sustain current activities

for another year without the prospect of deficit spending. He has illustrated that average dues for state medical associations across the country are \$140 annually, and has isolated the dues structures of states comparable to Oklahoma, most of which have annual dues in excess of these presently charged OSMA members. The Secretary-Treasurer, Doctor Haven Mankin, deferred this problem to the judgment of the House of Delegates, and your reference committee will respond to this matter in Item IV which follows. Your reference committee recommends the adoption of the Report of the Secretary-Treasurer.

Mr. Speaker, I move the adoption of this portion of the report.

A substitute motion was made to table this item until after the luncheon. The motion was seconded and carried.

The closing session of the OSMA House of Delegates recessed at 11:50 a.m. for lunch.

The closing session of the OSMA House of Delegates resumed at 1:40 p.m.

Item IV: Board of Trustees Report and Supplemental Report:

The annual report of the OSMA Board of Trustees illustrates responsible activity in a variety of areas of interest during the past organizational year, and the adoption of this report is recommended by your reference committee.

In the Supplemental Report of the Board of Trustees, a report of actions taken by the Board during this annual meeting, the Board took note of the Report of the Secretary-Treasurer concerning association finances. The Trustees observed that the association cannot operate at the same level without experiencing a deficit, especially if staff salaries are to be increased and if staff capabilities are to be expanded to meet expanding challenges. In its report, the Board took the position that the OSMA cannot be permitted to deteriorate in any fashion, and requested that the House of Delegates adopt a dues increase for 1976 in an amount not less than \$20 annually.

Your reference committee, after receiving testimony from a number of witnesses, concurs with the Board of Trustees that a 1976 dues increase is necessary and desirable. Recommendations from the witnesses ranged from a minimal \$20 per year increase to as high as \$55 annually. Since the association collects dues on a calendar year basis but operates on a fiscal year basis of June 1 through May 31,

only five-twelfths of the new dues income can be allocated to the fiscal year ending May 31, 1976. Thus, a \$20 dues increase would produce only about \$16,000 in new income for the next fiscal year, but would produce approximately \$40,000 the succeeding fiscal year. Your reference committee believes that this minimal increase would simply be maintaining the status quo and would not permit any great expansion of association productivity.

Conversely, a \$55 increase, in the opinion of your reference committee, would not be popularly received by the membership at this time.

Therefore, your reference committee strongly recommends that OSMA dues for 1976 be increased by \$30 to a total annual dues of \$150 annually. This amount would produce approximately \$25,000 in new income for the next fiscal year and would generate as much as \$60,000 for the following fiscal year.

Your reference committee feels constrained to observe that major issues currently confront the association, such as the matter of non-participation in federalized utilization review regulations. A strong stance against these regulations will present a major public relations problem to the association which cannot be sustained by any reasonable dues increase. Your committee, therefore, observes to the House of Delegates that major confrontations against onerous federal regulations will undoubtedly require a special assessment in order to develop a successful response to punitive federal actions which may be taken against the profession.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item V: Resolutions 2, 3 and 6:

These resolutions relate to the question of unified or voluntary membership in the American Medical Association. Because of their similarity in purpose, your reference committee considered these resolutions collectively.

Perhaps due to the location of the reference committee hearing room, your committee received only minimal testimony with respect to this very important issue. The number of witnesses appearing to speak on this question were so few that your committee did not feel that it could make an honest assessment of the attitude of the House of Delegates. Indeed, within the committee membership itself, there was an even division as to the repeal of re-

quired membership in the AMA. For these reasons, your reference committee feels that the matter must be referred back to the entire House of Delegates for discussion and decision.

In reviewing the three resolutions on this subject, your committee favors resolution No. 3 as submitted by the Tulsa County Medical Society, although it feels that the second "Whereas" beginning on line 4 refers to a referendum which was not completely unbiased.

Therefore, your reference committee recommends that a substitute resolution be adopted by the House of Delegates which incorporates lines 8 through 14 of resolution No. 3, to wit:

"RESOLVED, that the OSMA House of Delegates, acting at the annual meeting of April 23-26, 1975, approve appropriate amendments to the bylaws of the Oklahoma State Medical Association to delete the requirements that its members be members of the American Medical Association; and be it further

"RESOLVED, that the Oklahoma State Medical Association urge its members to voluntarily be members of the American Medical Association."

If it is the desire of the House of Delegates to adopt the preceding substitute resolution, then your reference committee recommends that the amendments contained in the report of the Constitution and Bylaws Committee be utilized as instruments to effect the change in policy toward AMA dues.

Mr. Speaker, we recommend that this issue now be opened for House consideration. The motion was seconded and it carried.

After considerable discussion on this subject, Doctor M. K. Braly called for the question and made a motion that the Speaker require a secret ballot. The motion was seconded and it carried.

The vote for mandatory membership in the AMA carried with 46 yes votes and 32 no votes.
Item VI: Resolution No. 1:

This resolution, submitted by the Oklahoma County Medical Society has the laudable purpose of endorsing a standardized health insurance claim form. It is the opinion of the committee that the form referred to in the resolution as the "American Medical Association Uniform Claim Form" is a form which is currently being perfected by the AMA, the Na-

tional Association of Blue Shield Plans, the Health Insurance Council and the Bureau of Health Insurance. However, since an informed representative of the Oklahoma County Medical Society was not present for the hearing, and since the committee was not possessed of a copy of the form in question, it was not felt to be wise to recommend passage of this resolution. The current OSMA policy is to endorse the Health Insurance Council COMB-I form, a form which is in actual use and which has been widely accepted by insurance companies.

Therefore, your committee recommends disapproval of Resolution No. 1 due to insufficient evidence as to the existence of the form in question.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item VII: Report of the Constitution and Bylaws Committee:

This report delineates amendments to the bylaws which would have the effect of making AMA dues voluntary; as mentioned in Item V above, although, the Constitution and Bylaws Committee adopted no position on the issue.

In addition, this report corrects oversights in the Constitution and recommends amendments to clarify the OSMA's relationship with "Oklahoma Medical Summit."

Your reference committee recommends adoption of this report.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Item VIII: Resolution No. 12:

This resolution has the purpose of providing that the AMA discontinue free distributions of all publications except JAMA, and that subscription prices be established by the AMA for other publications if feasible; further it recommends that fiscally unsound publications of the AMA be abandoned.

The second "Whereas" on line 5 and the third "Whereas" on line 9 contained statements which your reference committee cannot verify. In fact, the profit and loss picture of all AMA publications is presently under study by a special committee of the AMA House of Delegates in cooperation with a management consultant firm, and the findings of these activities are not available at this time.

Therefore, your reference committee recommends the adoption of the following Resolution No. 12, as amended:

"WHEREAS, the American Medical Associa-

tion has found itself in a financially embarrassing position and, therefore, has found it necessary to assess AMA members \$60; therefore be it

"RESOLVED, that the Oklahoma State Medical Association urge the American Medical Association to discontinue, immediately, free distribution of all publications, except for JAMA; and be it further

"RESOLVED, that the AMA establish a subscription price that will pay for its other publications, or, if such a subscription price is not feasible, that it discontinue, immediately, the publication of specialty journals, Prism, and all other magazines, leaflets, and brochures not fiscally sound."

Mr. Speaker, I move the adoption of this portion of the report.

After consideration of this item, the resolution was editorially amended to read as follows:

"WHEREAS, the American Medical Association has found itself in a financially embarrassing position and, therefore, has found it necessary to assess AMA members \$60; therefore be it

"RESOLVED, that the Oklahoma State Medical Association urge the American Medical Association to discontinue, immediately, free distribution of all publications, except for JAMA, and items of news or organizational interest; and be it further

"RESOLVED, that the AMA establish a subscription price that will pay for those other publications previously distributed as a benefit of membership, or, if such a subscription price is not feasible, that it discontinue, immediately, the publication of such specialty journals, and all other magazines, leaflets, and brochures not fiscally sound.

Mr. Speaker, I move the adoption of this portion of the report as editorially amended. The motion was seconded and it carried.

Item IX: Report of the Council on Insurance:

This report represents an assessment of the various insurance programs sponsored by the association on behalf of its membership. Your reference committee recommends approval of this report, and extends its appreciation for the splendid insurance program being furnished to OSMA members by the Council.

Mr. Speaker, I move the adoption of this portion of the report. The motion was seconded and it carried.

Mr. Speaker, I move the adoption of this re-

port as a whole. The motion was seconded and it carried.

Arthur F. Elliott, MD, Oklahoma City, Chairman

J. William McDoniel, MD, Chickasha

Elvin M. Amen, MD, Bartlesville

Charles Tefertiller, MD, Altus

Rollie Rhodes, Jr., MD, Tulsa

Robert A. McLauchlin, MD, Oklahoma City

Jack L. Berry, MD, Okarche

Don Blair, Staff

VI. PRESENTATIONS:

An AMPAC Award was awarded to Doctor Ed L. Calhoon, former Chairman of OMPAC and Doctor Kent Braden, present Chairman of OMPAC. The award was presented by Doctor Rex Kenyon, Member of the Board of Directors of AMPAC.

An Award of Appreciation was given to Doctor Howard Keith by Doctor Jack L. Richardson on behalf of his efforts on the OSMA Peer Review Committee.

VII. ELECTION OF OFFICERS:

The following Officers were elected:

Orange M. Welborn, MD, Ada, was elected to the office of President-Elect.

William M. Leebron, MD, Elk City, was elected to the office of Vice-President.

Haven W. Mankin, MD, Oklahoma City, was elected to the office of Secretary-Treasurer.

Ed L. Calhoon, MD, Beaver, was elected to the office of AMA Delegate.

M. Joe Crosthwait, MD, Midwest City, was elected to the office of AMA Alternate Delegate.

A motion was made to accept these appointments by acclamation. The motion was seconded and it carried.

VIII. ELECTION OF TRUSTEES AND ALTERNATE TRUSTEES:

The following Trustees and Alternate Trustees were elected by acclamation:

Trustee District XI: Atoka, Bryan, Coal, Choctaw, McCurtain & Pushmataha Counties

Trustee: B. R. McCann, MD, Durant

Alternate: Thomas E. Rhea, MD, Idabel

Trustee District XII: Carter, Love, Marshall, Garvin, Johnston, Murray & Pontotoc Counties

Trustee: Frank W. Clark, MD, Ardmore

Alternate: Clarence P. Taylor, MD, Ada

Trustee District XIII: Caddo, Comanche, Cotton, Tillman, Grady, Jefferson and Stephens Counties

Trustee: Paul N. Vann, MD, Lawton

Alternate: A. Craig Roberson, MD, Anadarko

Trustee District XIV: Greer, Harmon, Jackson, Kiowa & Washita Counties

Trustee: Lowell N. Templer, MD, Altus

Alternate: Fred W. Sellers, MD, Mangum

A motion was made to elect the trustees and alternate trustees by acclamation. The motion was seconded and it carried.

IX. ANNOUNCEMENT:

Doctor Stone introduced Doctor Kent Braden, Chairman of the OMPAC Board of Directors, who made a plea for 100% OMPAC membership and for sustaining memberships.

Doctor McIntyre stated that the Board of Trustees would meet immediately following the closing session of the House of Delegates.

X. ADJOURNMENT:

The 69th closing session of the House of Delegates adjourned at 3:05 p.m.

Recorded by Betty Lyles

Report of the
PRESIDENT
April 23, 1975
(APPROVED)

Mr. Speaker; Fellow Members of the House of Delegates:

Being allowed to serve you this past year as President of this great State Medical Association is an honor for which I am deeply grateful. The cooperation, assistance and kindness I have received in carrying out my obligations to this office have been a delight. Achievement would not have been possible without this fine support and I take this opportunity to thank you for it, one and all.

Upon assuming office last May, I at that time had plans to return from the upcoming June AMA Meeting and establish a widespread publicity program to inform our state citizens of the drawbacks of the PSRO Program as promulgated by HEW. My esteemed colleague, Joe Crosthwait, Chairman of our Public Policy Council, and I had previously talked at some lengths about this. Remember that not only did we have the consensus of our State Membership behind our efforts, but had secured commitments from seven of our national legislators. In addition, we felt the tenor of the previous meeting at Anaheim was a strong confirmation of our plan. Lo and behold, Oklahoma's surprise at Chicago when the House of Delegates ratified by a wide margin the plan of the Board of Trustees of the AMA to approve PSRO. This was embarrassing to

Oklahoma because we had assured our own Congressmen, as well as other legislators in Washington, that medicine was strongly opposed to this program. The House of Delegates acquiesced to the Board of Trustees, however, and endorsed PSRO. It is sad that not one of the modifications the Board of Trustees had suggested has ever been granted. It is a credit to Oklahoma's delegation that they never waived in their stand, while about them state after state, many of whom had made written or oral commitments to hold strong against government intervention, capitulated. Oklahoma's solid stand is evidence of its philosophic fidelity.

Thereupon, your State Association turned its effort to critical problems at home. Our Medical School and Health Sciences Center were in serious difficulty and at a stalemate with the Legislature. We felt that our State Association could perhaps aid them when they could not do it for themselves. I appointed a tenacious, aggressive, public-spirited doctor as Chairman of the Medical School Liaison Committee, C. S. Lewis of Tulsa. Together he and I spent countless hours with the University President, the Acting Provost, Acting Dean, Legislators, Regents, candidates for Governor and medical school faculty. Fine cooperation was obtained from all. Our membership contributed to the development of a sound-slide program which was taken throughout the state, some twenty-five showings being given. The rest is history! The Medical School has a new Provost and is better financed now than ever before. Full financing for the coming year has been assured. Doctor Lewis and his committee — and you — are deserving of high praise for this concentrated effort leading to success.

In addition to the gains just described, there are also Family Practice Residencies in Oklahoma City and Tulsa and a satellite program is being planned for other areas of the state, the first of which is to be at Enid. The Tulsa Medical Branch is underway and off to a good start.

Our combined annual meeting has proved a success with a larger attendance than has ever been experienced before, thanks to fine cooperative efforts of the three component organizations.

Your State Association has purposely been one of the very last to apply for a PSRO Planning Grant, but this has not deterred Doctor Hillard Denyer, Chairman of the Oklahoma Foundation for Peer Review, from working diligently with his committee in anticipation of

the possible ultimate necessity. Meanwhile, we have had perhaps an even more onerous government program dropped on us in the way of P.L. 93-641, the Health Planning Bill, that would tell us where, when and how to practice. HEW attempted to force on us pre-hospital certification for our patients and then utilization review, the latter so lacking in circumspection that no thought had been given to the fact that smaller hospitals could not possibly comply with its regulations. These, of course, will be only two of the innumerable defective regulations that will be foisted upon the profession and the public. It is to the great credit of the AMA that it has filed suit challenging in court constitutionality of Utilization Review, while public reaction forced a delay in implementing pre-hospital certification. Please note, however, that Mr. Weinberger has not granted permanent relief from such pre-hospital certification, only agreeing to a delay.

Our national organization has found itself in economic difficulties, this being the fifth year in six that has ended with a marked deficit. With the insistence of certain alarmed and intrepid groups and members, there has been an attempt to economize by eliminating certain programs in order to become fiscally sound. Again your State Delegation was active in requesting financial responsibility, although not without being considered audacious by the Board of Trustees. The main point is, the effort was successful. Just last month, the Board of Trustees of AMA approved a planning program including "possible changes in the organizational structure of the AMA, both internally and as a federation." Information more specific than this has not been revealed, but is promised us in June in Atlantic City.

Our State Organization has reaffirmed the advisability of continuing the medical research program at the McAlester Penitentiary, has actively supported loans to deserving medical students, has furthered continuing medical education and has encouraged medical service in rural areas.

I have great admiration for the hard work, loyalty, integrity and dependability of our Committee Chairmen and their constituents. We have a state membership to be proud of for its ethics and its devotion to the service of the public and this has made me very proud indeed to be its spokesman for the past year.

Doctor Buck Wagon, a prime organizer if ever there was one, together with his hard working and efficient committee have de-

veloped this meeting which portends to be the best this State has ever known.

I would indeed be remiss if I did not give full recognition and thanks to our three fine Executive Directors in the Association's offices. No President could function properly without them. They are knowledgeable, efficient, pleasant and productive. I doubt that any medical organization has three who are finer.

There is, sadly, another great crisis facing our Profession across this great land and I refer to professional liability. We in Oklahoma are enjoying at the present time a favorable situation, as compared with most other states, but we in the Midwest cannot rely on the hope that this will continue. We must prepare for the possibility that devastating effects may reach us as well. Recently, our national organization has recognized that this crisis does exist and has agreed to help, although stating it is primarily a state problem. Our efforts to decrease our jeopardy must be carried out with great circumspection, but with equal determination.

Finally, I say once again, to you the leaders of this great State Medical Association, that I am deeply indebted to you for your confidence and your great assistance. I could not have worked for or with finer gentlemen in meeting the challenge that this office of President presents. I salute you!

Jack L. Richardson, MD
President

Report of the
PRESIDENT-ELECT
(APPROVED)

Mr. Speaker, Doctor Richardson, Members of the House:

During the past year, the work of our President, Doctor Jack Richardson, has been very outstanding. He has worked with untiring energy and the Society owes him a debt of gratitude.

The Committees have functioned very commendably during the past year. I want to thank all of you who participated in the committee work, for this is the basis and background of our State Medical Association. The work of two of our committees I feel has been tremendously outstanding.

The Legislative Committee has done a yeoman's job during the past year, under the direction of Doctor Barton Carl and under the Staff Leadership of Mr. David Bickham. These

men, along with the other members of the Committee, have done a tremendous job.

The Medical School Liaison Committee, headed by Doctor C. S. Lewis, Jr., of Tulsa has done an outstanding job during the past year.

Resolutions: There are a number of resolutions being proposed to which I would like to speak.

Resolution No. 12 concerning AMA publications. I would recommend that this House approve that resolution on to AMA in Atlantic City.

Resolution No. 1 concerning insurance claim forms. I would recommend that this house approve that resolution.

Resolutions Nos. 2, 3, and 6 proposing voluntary AMA membership, instead of mandatory membership. I would recommend that these resolutions be put together into one substitute resolution and that this house approve such resolution, making the effective date of this change on January 1, 1976. I would however, encourage that all members of the Oklahoma State Medical Association remain members of the American Medical Association. There are many reasons why we should remain members of the AMA. First and foremost is because of the instability of Medical Liability Insurance today. It may come to a point where we have to be members of the AMA in order to get Medical Liability Insurance. Let's don't be caught without it.

Resolutions Nos. 10 and 13. Non-participation in U.R.

Resolution No. 14. Restrict the sale of syringes.

The Oklahoma Medical Summit — As you know, this is the second undertaking of the Oklahoma Medical Summit. It appears at this time that the upcoming Summit meeting will even be a greater success than the Oklahoma Medical Summit meeting of 1974. All of you know that meetings, the caliber of this one coming up, *don't just happen*. This meeting has been put together under the direction of Doctor Buck Wagon. Buck has done a tremendous job. Working with Doctor Wagon have been three representatives from each of the participating organizations, three from the Oklahoma State Medical Association, three from the Oklahoma Academy of Family Physicians, and three from the Oklahoma City Clinical Society. This entire committee has been a

very dedicated group, and the results will show it. All three of the staff men of the Oklahoma State Medical Association have worked hard on their particular areas of the Oklahoma Medical Summit, Mr. Blair, Mr. Bickham and Mr. Kelsay. Harl Stokes, representing the Oklahoma City Clinical Society, and the Academy of Family Physicians has also done a tremendous job, and we thank all of them for their participation in this very worthwhile project. Dee Hampton, the Executive Secretary of the Oklahoma County Medical Society, has also done a great job.

Mr. Speaker, I have two specific recommendations in my address here today. I would like for this address to be assigned to one of the reference committees for approval or disapproval. Now please do not misunderstand me. Just because I am the incoming president, I do not expect this House of Delegates to act hastily on any recommendations that I come up with. I have, however put in a considerable amount of thought, and had much consultation from other members of the Society, before making any recommendations. I would like to make one specific recommendation regarding the Oklahoma Medical Summit.

Recommendation No. 1: I would like to recommend that our House of Delegates approve upcoming meetings of the Oklahoma Medical Summit in Oklahoma City for at least the next three years. Many times, on the short notice we have had it is somewhat difficult to obtain some of the speakers and some of the commitments that we could have otherwise had, had we had a longer notice.

Recommendation No. 2: I recommend that your new president be allowed to appoint an Ad Hoc Committee to study the Committee structure of our Association, and that the Ad Hoc Committee be chaired by our new President-Elect whoever he may be. Councils and Committees should be studied and defined.

PSRO AND UR: Professional Services Review Organizations and Utilization Review. These two monsters continue to haunt us and the problems change in these areas from day to day, but whatever the change, let it be the policy of our State Medical Association to fight all government, and other third party interference with every method at our disposal. The Federal Government interference continues to pop up at every turn. We of the Medical Profession must continue to support whatever policy can deliver the best medical care possible to our patients of Oklahoma.

I want to acknowledge and thank the Auxiliary to the Oklahoma State Medical Association. Their diligence and untiring work goes on, and we do appreciate it.

I want to publicly thank the new Committee Chairmen who have already accepted positions. It is through the Committees that we can make our State Association a successful medical organization.

I want to ask the new officers who will be newly elected this Friday and the hold-over officers for their support. They will be called on many times for consultation and other help. I will depend upon you.

During the past year I have been in the position to observe the efficient work of our small Executive Staff and their secretaries. Gentlemen, we have about the most efficient Executive Staff in our headquarters office of any state in the country. Our secretarial help is excellent, but gentlemen, we are sorely understaffed, so it is up to you and me to make an even greater contribution in the coming year, and the coming years. It may be necessary to hire some more people in the coming years. I want to pledge the Oklahoma State Medical Association's continued support of the Oklahoma Health Sciences Center, and their administration. I want to extend a special welcome to Doctor William Thurman, the new Provost of our Oklahoma Health Sciences Center. Doctor Thurman, we pledge our support in every way, to you, and to our Health Sciences Center. I want to acknowledge the fine work of our Dean, Doctor Tom Lynn and his staff, and pledge our continued support of the Oklahoma University Medical School. Mr. Speaker I want to acknowledge the fine work of our Oklahoma State Health Department. Doctor LeRoy Carpenter and his staff have turned our State Health Department into a responsive and responsible organization within the Medical Profession. We are proud of it. We are happy to work with you, and we pledge our support.

This year I am having a Committee on Sports Medicine, a new committee — are there any volunteers?

I would strongly recommend that we continue cooperation among all physicians throughout our State, even though we have some differences of opinion, our overall goals are the same, we must continue to fight for a common goal, that will continue to give our patients the best medical care in the world. Let the town and gown join hands. Let all

specialists and generalists unite and work together to make Oklahoma a better place in which to live and an even better place in which to practice medicine.

Mr. Speaker, in this address I have two specific recommendations. I request that this portion of my report be referred to the appropriate reference committee for recommendation back to this House of Delegates. I thank you for the opportunity to appear before this House of Delegates today. *Arnold G. Nelson, MD*

Report of the BOARD OF TRUSTEES (APPROVED)

This report summarizes principal actions taken by the Board of Trustees since the last annual meeting. Actions taken by the Board at its April 23rd meeting will be contained in a Supplemental Report.

Actions reported from the July 14th, November 17th and March 9th Board meetings are as follows:

1. The Board of Trustees approved a major campaign to bolster the University of Oklahoma Health Sciences Center by preparing informative printed materials to distribute on a statewide basis, by developing a sound-slide presentation about the OUHSC concerning its achievements, its problems and necessary solutions, and by conducting regional meetings throughout the state on an urgent basis to present a constructive program to physicians, legislators and civic and business leaders. Up to \$20,000 was authorized by the Board for this major and critical activity, and a voluntary fund raising campaign was authorized to be carried out among the membership to help defray the total costs. Total costs of this very effective campaign carried out by the Medical School Liaison Committee were \$10,550 of which \$3,300 was taken from association reserves and \$7,250 was generously donated by OSMA members.

2. The Board of Trustees, acting on the authority extended to it by the House of Delegates, and confronted by a 202-24 vote of the AMA House of Delegates in June which defeated any AMA effort to repeal the PSRO law, voted on July 14th to authorize the Oklahoma Foundation for Peer Review to apply for a federal planning contract to further develop an operational concept for PSRO in Oklahoma. At the time of this action by the Board, it was

expected that the federal Office of Professional Standards Review would solicit contract proposals in September. However, Congress was slow to act on a PSRO budget request of \$58 million for the fiscal year, and the final action taken by House-Senate conferees was to appropriate only \$37 million for this activity. The \$21 million budget cut resulted in further delays in new PSRO activity, and at this writing there have still been no federal solicitations for new PSRO contracts. However, at its November 17th meeting, in anticipation that contract proposals would soon be solicited, the Board authorized the Foundation to develop a planning contract proposal with the proviso that it be resubmitted to the Board of Trustees for final approval and, further, that it not be submitted to Washington in advance of a definite contract solicitation. At its March 9th meeting, the Board received and approved a proposal prepared by the Oklahoma Foundation for Peer Review for a \$117,000 six-month planning contract. To date, the federal Office of Professional Standards Review has yet to open contract bids and the proposal has not been submitted to Washington.

3. On November 29th, the Secretary of HEW issued new hospital utilization review regulations affecting Medicare and Medicaid patients. Initially, efforts were made by the Oklahoma Foundation for Peer Review to use the PSRO knowledge it had gained to assist Oklahoma hospitals in meeting the regulations, especially since the Secretary's regulations left every hospital to its own devices to determine medical criteria and operational procedures. Meanwhile, it became evident that some 50 smaller hospitals in Oklahoma could not possibly comply with the regulations, and the Board instructed the Executive Director to issue a press release critical of the regulations and supportive of the efforts of small hospitals to resist this imposition. Subsequently, the OSMA Executive Committee, acting within its delegated authority, issued a statement to all county medical societies and hospital chiefs of staff urging them to delay any affirmative action on the regulations pending the outcome of a lawsuit filed by the AMA against the Secretary of HEW for the purpose of seeking an injunction against implementation of the regulations. This matter has continued to generate controversy within the state and will be a sub-

ject for further consideration at this annual meeting.

4. The Board took swift action in responding to Public Law 93-641, the National Health Planning and Development Act of 1974, a program which could exact sweeping changes in health care delivery and exact new and unprecedented pressures on physicians, hospitals and nursing homes. At its March 9th meeting the Board was advised that precipitous federal deadlines had been imposed regarding the division of Oklahoma into health planning areas (called "Health Service Areas" in the law). The Governor is required to submit such divisions to the Secretary of HEW by May 3rd, and to meet this deadline he scheduled 13 public hearings throughout the state on March 20th and sought recommendations from all interested groups by April 3rd. A special OSMA Ad Hoc Committee was appointed and instructed by the Board of Trustees to develop a plan incorporating the concept of multiple, autonomous HSA's. The committee, with the help of additional members of the Board of Trustees, had representatives at the regional hearings who testified as instructed, and an OSMA plan to divide the state was developed and submitted to the Governor by the April 3rd deadline after having been approved by the Board by mail ballot.

5. The Board took action on a proposed AMA dues increase (to raise 1975 AMA dues from \$110 to \$200). Acting on the results of a poll of 25% of the OSMA membership conducted by President Richardson, which revealed overwhelming opposition to the increase, the Board left the OSMA Delegates to the AMA meeting in Portland "informed" but uninstructed as to their voting on this issue (OSMA Delegates voted against the dues increase, which failed and against the \$60 assessment, which passed).

6. The Board adopted a position paper on "Unionism in Medicine" which, generally speaking, took the position that, except for employed physicians (ie. house staff), there appears to be little that a union can do for self-employed physicians in the area of bargaining that a professional association cannot do as well. The Board of Trustees will continue to assess the union movement in medicine and adjust its policy as indicated.

7. The Board approved a resolution to be submitted to the AMA House of Delegates at its Clinical Convention in Portland which had the effects of (1) providing for more local input

into the formulation of AMA positions on national legislative issues, and (2) providing for decentralization of the AMA lobbying effort for the purpose of bringing the full strength of American Medicine to bear on high priority bills. This resolution and several like it from other states were shelved by the AMA House of Delegates.

8. Certificates of Accomplishment were approved by the Board on behalf of Robert M. Bird, MD, former Dean of the University of Oklahoma College of Medicine, and Howard B. Keith, MD, former Chairman of the OSMA Peer Review Committee. These awards are herewith recommended for final adoption by the House of Delegates.

9. Harry Wilkins, MD, Oklahoma City, was selected by the Board to receive the 1975 A. H. Robins' Physicians Award for Community Service.

10. Trustees endorsed in principle House Bill 1552 to establish a commission and to provide funding for internship and residency training programs in Oklahoma.

11. Because of a nationwide decline in the professional liability insurance market, and other adverse factors which have created crises in other states, the Board of Trustees, on recommendation of President Richardson, voted to create an Oklahoma Professional Liability Study Commission.

12. The OU College of Medicine faculty has created an "Extramural Relationship Committee" for the overall purpose of strengthening liaison with the practicing medical community and the public. They will host a reception for OSMA Officers and Trustees at the Summit meeting and have requested that the Provost of the OUHSC and the Dean of the College of Medicine be appointed routinely on the OSMA Medical School Liaison Committee, to which the OSMA Board has agreed. Beginning with the 1976 annual AMA convention, the faculty committee will host a reception for OU alumni and OSMA officials attending the meeting to acquaint them with AMA business matters affecting medical education.

13. Because of resolutions now pending before the House of Delegates, the Board voted to retain AMA dues collections in Oklahoma until such time as the House decides whether or not to amend the bylaws to make payment of AMA dues voluntary rather than mandatory.

14. The Board appointed the following individuals to serve as the OSMA representatives on the Oklahoma Council for Health Careers:

Mrs. William Renfrow, President-Elect of the Woman's Auxiliary; Marcella Steele, MD, Tulsa; David Bickham, OSMA Associate Executive Director.

15. The Board voted to co-sponsor a Leadership Training Program for officers and key committee personnel in cooperation with the Oklahoma Academy of Family Physicians, the Oklahoma County Medical Society and the Tulsa County Medical Society.

16. A 1975-76 Board of Directors was appointed for the Oklahoma Medical Political Action Committee.

17. Life Membership Applications were received from county medical societies and were approved by the Board on behalf of the following physicians: B. B. Coker, MD, Durant; C. F. Paramore, MD, Shawnee; L. J. Starry, MD, Oklahoma City; Charles A. Royer, MD, Sarasota, Florida; John R. Little, MD, Oklahoma City; William Mussil, MD, Oklahoma City; George H. Garrison, MD, Oklahoma City; Floyd T. Bartheld, MD, McAlester; L. Chester McHenry, MD, Oklahoma City; Howard C. Martin, MD, Oklahoma City; Donald L. Mishler, MD, Tulsa; J. D. Shipp, MD, Tulsa; Marcella R. Steele, MD, Tulsa; Thomas L. Foster, MD, Ponca City.

18. Doctor Robert Bird was elected as a Corresponding Member of the OSMA.

19. Arthur I. Taubman, DDS, an oral surgeon from Tulsa, was elected as a dues-paying Affiliate Member of the OSMA.

20. Five OSMA members were excused from paying 1975 dues as a result of financial hardship.

21. The following physicians were awarded 50-Year Pins in the OSMA: L. Chester McHenry, MD, Oklahoma City; William N. Mussil, MD, Oklahoma City; L. J. Starry, MD, Oklahoma City; George H. Garrison, MD, Oklahoma City; B. B. Coker, MD, Durant; and Charles F. Paramore, MD, Shawnee.

22. The Board has recommended two nominees for one appointment to the State Board of Health: Francis W. Hollingsworth, MD, El Reno; and, William McDoniel, MD, Chickasha.

23. The Board of Trustees has authorized the association president to select nominees to submit to Governor Boren to fill vacancies on the State Board of Medical Examiners which were not attended to during the tenure of Governor Hall.

24. For one appointment on the Board of

Mental Health, the OSMA Board has sent the names of three nominees to the Governor: Charles Smith, MD, Oklahoma City (incumbent); Max A. Glaze, MD, Muskogee; and Wayne J. Boyd, MD, Bartlesville.

25. The Board of Trustees reports the following breakdown of membership:

Active Members	2,077
Active Dues-Exempt Members	34
Applications Pending	140
Life Members	177
Affiliate Members	6
Honorary Members	11
Junior Members	129
Total Membership	2,574

Supplemental Report BOARD OF TRUSTEES (APPROVED)

At the annual meeting of the Board of Trustees held at 9:00 a.m. on April 23rd, the following actions were taken:

1. John A. McIntyre, MD, Enid, was re-elected to a one-year term as Chairman of the Board of Trustees; James B. Eskridge, III, MD, Oklahoma City, was elected Vice-Chairman of the Board.

2. The Board reviewed business items to be considered by the House of Delegates during this annual session and took note of the Secretary-Treasurer's Report, a report which reveals a bleak financial picture for the next fiscal year.

In the report, the Secretary-Treasurer explains that OSMA dues have been constant from 1973 through 1975, a period of three years of consistent dues costs during a time of significant inflation. In addition, the Secretary-Treasurer noted that average dues for state medical associations are \$140 per year, and itemized a number of comparable state associations whose dues are considerably higher than those currently charged by the OSMA.

The Board of Trustees observed that the association cannot operate another year at the same level without experiencing a deficit, especially if staff salaries are to be increased and if staff capabilities are to be expanded to meet expanding challenges. Moreover, the value of the OSMA to its membership was discussed, and despite the Board's knowledge that many OSMA members may resist a dues in-

crease in any proportion, it was generally agreed that our state association must not be permitted to deteriorate in any fashion.

With these realities in mind, the Board of Trustees voted to request that the OSMA House of Delegates adopt a dues increase for 1976 in an amount not less than \$20 annually. This increase will be consistent with dues charged by other state associations and is felt to be a reasonable reaction to the increasing costs of operating our organization.

3. The Board accepted late resolutions Nos. 12, 13, 14, 15 and 16.

4. In response to requests from county medical societies, the Board adopted guidelines entitled "Telephone Directory Listings for Physicians and Surgeons" as prepared by the Judicial Council of the American Medical Association. The Board recommends that these guidelines be furnished as such to all county medical societies for their consideration as to local adoption and use.

5. The Board of Trustees, responding to local problems and to recent action taken by the Judicial Council of the American Medical Association, adopted as policy the following statement related to interest charges on delinquent accounts:

"The Judicial Council has considered the matter of charging interest on unpaid bills of physicians regularly over the past 8-10 years. It adopted the following opinion in 1962:

"Since the practice of medicine is a profession and not a business, the practices adopted by businesses are not necessarily suitable to medicine. It is not in the best interest of the public or the profession to charge interest on an unpaid bill or note for professional services not paid within a prescribed period of time nor is it proper to charge a patient a flat collection fee if it becomes necessary to refer the account to an agency for collection.

"Despite requests to modify or rescind this opinion, this Council has no information or data which would indicate that charging interest reduces the physician's accounts receivable or materially changes patient's paying habits. In view of this, the Council reaffirms its 1962 opinion regarding interest charges and flat collection fees.

"It is not improper, however, for a physician to add a service charge, equal to the actual administrative cost of rebilling, on accounts not paid within a reasonable time. Patient must be notified in advance of the existence of this practice."

6. The following physicians were re-appointed by the Board of Trustees to full three-year terms on the Board of Directors of the Oklahoma Foundation for Peer Review: Rollie E. Rhodes, Jr., MD, Tulsa; Arthur E. Schmidt, MD, Oklahoma City; Maurice C. Gephardt, MD, Muskogee; and William M. Leebron, MD, Elk City.

7. In accordance with procedures for appointment of the Board of Directors of the Oklahoma Medical Political Action Committee, the OSMA Board of Trustees has added Jack L. Richardson, MD, Tulsa, and Mrs. Scott Hendren, Oklahoma City, to the 1975-76 OMPAC Board of Directors.

8. Robert G. Tompkins, MD, Tulsa, has been re-appointed to a three-year term on the Editorial Board of *The Journal* of the Oklahoma State Medical Association.

9. The following physicians have been selected by the OSMA Board of Trustees as nominees for one position on the State Health Department's "Health Facilities Advisory Council": A. L. Johnson, MD, El Reno; Frank W. Clark, MD, Ardmore; and Orange M. Welborn, MD, Ada.

10. The Board of Trustees reaffirmed its continuing sponsorship of the "Governor's Committee on Employment of the Handicapped" at the rate of \$250 per year.

11. An Affiliate Membership in the OSMA was approved for Donald C. White, MD, who practices in both Kansas and in Bartlesville, Oklahoma. At the Board's option, in accordance with OSMA bylaws, Doctor White will be expected to pay full OSMA dues.

12. The Board of Trustees received a complete report on the history and current status of the association's sponsored professional liability insurance program, as presented by Don Blair, Executive Director and Rod Frates, OSMA Insurance Counselor. In short, the association program presently enjoys the lowest premium rates in America and continues to operate on an actuarially sound basis. However, because of external problems as evidenced by an almost total decline in the professional liability insurance market, and other factors such as unreasonable shock losses being incurred in other states, cost adjustments in the OSMA program may be experienced in 1976. The Board of Trustees commended Mr. Frates and the Council on Insurance on the quality and thoroughness of their report and expressed confidence in their ability to maintain professional liability coverage for

Oklahoma physicians at the lowest possible rates and under the best possible conditions.

13. Dues for 1975 by the United States Chamber of Commerce were approved by the Board of Trustees in the amount of \$250.

14. The Board took note that proposals contained in resolutions 5, 9, 10 and 13 could result in the association's involvement in a public relations program of significant magnitude. While the Board does not wish to instruct the House of Delegates or the reference committee in any fashion regarding these resolutions, it respectfully requests that any action taken by either the reference committee or the House with respect to utilization review regulations and/or PSRO should be taken in a manner which will accommodate the cost of carrying out the adopted position in a successful way.

15. The Board of Trustees commends the Editorial Board of *The Journal* of the Oklahoma State Medical Association, and the Executive staff of the OSMA, for the quality of the OSMA's official publication, especially the March issue on professional liability.

Report of the
SECRETARY-TREASURER
(APPROVED)

Financial Statement

The association's fiscal year ends on May 31st, at which time a complete audit of all accounts will be prepared. In order to provide the Delegates with an indication of the financial status of the OSMA at this time, however, the following estimates of income and expense, excluding the annual meeting, are presented:

INCOME

Dues	\$230,000
Interest	8,500
AMA Commissions	2,200
Building Lease	4,200
Other Commissions	2,169
OUHSC Voluntary Contributions	7,250
Directory Income	3,500
Journal Advertising Sales	25,000
Estimated Total Income	\$282,819

EXPENSE

Fixed (General	
Administration)	\$170,000
Depreciation	5,000
Councils and Committees	13,000

Student Loan Fund	10,000
In-State-Travel	5,500
Out-State-Travel	19,500
Dues, Okla. Council for Health Careers	2,000
Newsletter	2,000
Mortgage Payment	641
Journal	40,000
Directory	10,000
Commissions to County Societies	2,010
Estimated Total Expense	\$279,651
Estimated Surplus	\$ 3,168

At the last annual meeting, prior to expenditures made during the meeting, a budget for the fiscal year just ending predicted an estimated surplus of \$16,400. However, as a result of salary increases and overestimates of dues income and Journal income, the expected surplus was necessarily altered downward. Nevertheless, if the expense estimates for the current year prove to be correct, the predicted expenditures of \$279,651 compare favorably to budgeted expenditures of \$276,600.

It is clear, however, that a marginal income to expense ratio has been reached in OSMA operations, although the foregoing estimated surplus could possibly be enhanced if "Oklahoma Medical Summit" produces a surplus as it did last year.

During the next fiscal year, June 1, 1975 to May 31, 1976, it is expected that inflation will continue to occur across-the-board. For example, there will be a 10% increase in Journal printing costs (which, hopefully, will be offset for the most part by a corresponding increase in Journal advertising rates if we are able to maintain the same number of advertising pages in an increasingly competitive field).

The OSMA dues were last raised in 1973 . . . from \$100 to \$120.

1975-76 Budget

With an estimated operating surplus for the current year of only \$3,168 (plus any windfall which may result from the "Summit" meeting), it appears unlikely that OSMA operations can be sustained at the same level without suffering an operational loss. The average 1974 dues for all state medical associations, according to the best information available is \$140. The

current dues for states of comparable size to Oklahoma are as follows: Arizona — \$130; Colorado \$150; Iowa — \$200; Kansas — \$125; and Oregon — \$155.

With the foregoing information about the current fiscal year in mind, and without assuming a dues increase, it is difficult to present a favorable budget for the coming year. However, the following is a "best estimate" of what can be done:

INCOME

Dues	\$233,000
Interest and Commissions	9,500
Building Lease	4,200
Journal Advertising, Sales	25,000
Directory Sales	3,000
Estimated Total Income	\$274,700

EXPENSE

Fixed (General Administration)	\$175,000
Depreciation	5,000
Councils and Committees	
Public Policy	4,000
Insurance	1,000
Professional	
Education	2,500
Socioeconomic	
Activities	1,000
Public Health	1,000
Prof. and Inter- vocational Relations	500
Journal	42,000
Newsletter	2,000
Student Loan Fund	10,000
In-State Travel	6,000
Out-State Travel	21,000
Oklahoma Council for Health Careers	2,000
Commissions to County Societies	1,500
Estimated Total Expense	\$274,500
Estimated Surplus	\$ 200

Again, annual meeting income and expense are not included in the budget estimates, since the format of each meeting and income-producing potentials are not predictable. Neither do the preceding budgetary estimates accommodate salary increases.

RECOMMENDATION:

1. The financial circumstances of the Association are self-evident, and the House of Dele-

gates is invited to address itself to the situation.

Report of the
COUNCIL ON INSURANCE
(APPROVED)

Council Members

C. Alton Brown, MD, Oklahoma City, Chairman
Robert W. Kahn, MD, Oklahoma City
Howard A. Bennett, MD, Bartlesville
David D. Fried, MD, Altus
C. E. Woodard, MD, Tulsa
William G. Bernhardt, MD, Midwest City
William M. Leebron, MD, Elk City
Glen L. Berkenbile, MD, Muskogee
Robert A. Nelson, MD, Tulsa
Thomas C. Glasscock, MD, Ponca City
Roger Haglund, MD, Tulsa

SECTION I.

Group Term Life Insurance

The Group Term Life Insurance Program of the OSMA is underwritten by the Massachusetts Mutual Life Insurance Company and has been in effect since 1956. Since the inception of the plan \$958,027 has been paid out in claims to members or to the heirs of members of the OSMA. Two hundred sixty-one physicians' wives are now protected under this competitive program.

Loss experience during the last year has been excellent. In fact, a dividend in the amount of \$2,297.95 was returned by the Massachusetts Mutual to the OSMA. This dividend will be carried forward as a credit against the billing for each physician's policy in the coming year. If good experience continues, we should enjoy another dividend this year.

In addition to life insurance, the policy also includes features for dismemberment and loss of sight benefits, waiver of premium if disabled, and private flying coverage. In addition, no individual physician may be cancelled unless the entire program is terminated.

SECTION II.

Disability Income Insurance

The OSMA disability income insurance program is underwritten by the Washington National Insurance Company. Doctors insured under the program may select up to \$2,500 a

month indemnity for periods of disability due to illness or accident. There are optional waiting periods before disability coverage begins, and either a 5 year or "to age 65" benefit period may be selected for disabilities due to illness (life time benefits are payable in case of accident). Coverage is also available for private pilots and there is an accident benefit of \$5,000 for death or dismemberment.

Currently some 600 OSMA members are protected under the program and last year physicians received benefits from the plan in the amount of \$86,708.

Loss experience has been optimum over the years of sponsoring the program, and it continues to be predictable.

SECTION III.

Overhead Expense Insurance

This program is underwritten by the Continental Casualty Insurance Company. The program is doing very well from a loss standpoint. However, even with the growth produced during the last year's active solicitation, the program is still not as well participated in as many other sponsored insurance programs of the OSMA.

The program indemnifies a physician against the cost of keeping his office open during periods of disability. From \$300 to \$1,500 a month coverage may be purchased for a disability period of 18 months. Benefits may be used to pay the actual overhead costs, including employees' salaries, during periods of disability.

Premium costs are tax deductible.

According to insurance experts, physicians more and more tend to buy additional disability income rather than overhead expense coverage. Overhead expense insurance is, however, still extremely valuable to the individual physician in private practice. It provides coverage above and beyond his disability coverage at minimal price. Furthermore, there is a growing trend toward limiting the amount of disability income coverage an individual may purchase. As this trend gains momentum, overhead expense plans may well enjoy a surge in popularity. For the rural physician in the small town in individual practice, this plan is an inexpensive way of picking up vital insurance.

SECTION IV. *Major Medical Insurance*

This is the newest insurance program being promoted by the OSMA. It is underwritten by the Washington National Insurance Company. Apparently there are now 151 participants in the program and although the loss experience is too green to determine its rate liability at this time, it does appear to be stable and predictable.

Since its inception on January 1, 1973, many changes have been made in the program in an effort to improve it and make it more competitive. Coordination of benefits has been provided and most recently claim service has moved from the home office of the company to Oklahoma City. This move will facilitate rapid and more accurate handling of claims.

A number of options are available in order that a physician may design a program to meet his own needs. The Council on Insurance anticipates a major push during the coming year to increase the enrollment in the program.

SECTION V. *Excess Limits Liability Insurance Program*

The OSMA's Excess Limits Liability Insurance Program is underwritten by the CNA Insurance Company. Two years ago the INA withdrew from the excess limits market nationwide. At that time the OSMA Council on Insurance established criteria for a replacement company. Only one company, CNA, met the criteria, and agreed to underwrite the program in Oklahoma. While there is no acceptable method of fairly comparing the price of this type of insurance to other programs like it, because of the coverage of professional liability, the rates in the program are considered to be extremely competitive.

Most umbrella type coverages for individuals extend to such well known liabilities as automobiles, watercrafts, aircrafts, homeowners, etc. However, in the case of a physician, the umbrella coverage also extends to his professional liability. The CNA umbrella program drops down to the \$100,000 limit of the basic professional liability coverage offered in the state of Oklahoma through INA, and goes up to

a \$5 million limit based on the physician's needs.

At the present time, more than 1,600 physicians in the state of Oklahoma have purchased the umbrella insurance in addition to their basic professional liability program. The loss experience in the plan is good at this time, but it must be kept in mind that as professional liability losses exceed the \$100,000 cushion, the loss experience in excess limits could go up. At the present time, losses in excess of that amount are extremely infrequent. If the basic professional liability program continues to be stable, then the excess limits liability program should remain sound.

SECTION VI. *Professional Liability Insurance*

The OSMA's Professional Liability Insurance Program is underwritten by the Pacific Employers Indemnity Company, a wholly owned subsidiary of the Insurance Company of North America. It has now been in force since 1967 and has provided a stable liability coverage for Oklahoma physicians.

Before going into a discussion about Oklahoma's Professional Liability Program, it would be best to review the national situation. Needless to say, the national situation is bleak. There are entire states that are unable to purchase professional liability coverage at any price. Companies that have written this type of program for years are getting out of the market. It is projected that Class 5 physicians (anesthesiologists, orthopedic surgeons, plastic surgeons, etc.) may have to pay as high as \$40,000 for their coverage next year in the state of New York. In other states premium increases from 100 to 1,000 percent have been announced.

The medical liability insurance situation nationwide has reached crisis proportions. There is now congressional interest in the situation and several professional liability proposals have already been introduced in the U.S. Congress.

Senator Ted Kennedy of Massachusetts has seen the crisis as another opportunity to control and direct a provision of medical care in the United States. He introduced the National Medical Malpractice Insurance and Arbitration Act of 1975 which would authorize the Secretary of HEW to contract with "providers of

health care services" who would choose to participate in the program. The providers would then pay an annual premium to a medical malpractice firm and would receive federal coverage. In return for the federal coverage, participants would be required to comply with state licensure and relicensure requirements which meet or exceed minimum standards to be established by the Secretary of HEW. In addition, participating physicians would also agree to accept review of their services by PSRO's, to accept as payment in full whatever amount Medicare would establish as reasonable, and would obtain concurring opinions from a specialist prior to performing surgical procedures. In addition, all malpractice claimants and medical care providers would submit medical malpractice disputes to non-binding arbitration.

Senator Gaylord Nelson of Wisconsin has introduced a bill which would authorize HEW to set up a re-insurance program and to conduct studies and experiments in professional liability coverage.

A major concern of your Council on Insurance is that the "cure" to the malpractice situation in other states might be a "fatal disease" for Oklahoma's program. At the present time legislation is pending in almost every state in the union to help the malpractice situation. Some of that legislation could affect the state of Oklahoma. As an example, the state of New Jersey considered writing a state law that would require any insurance company doing business in that state that was writing professional liability in any other state to also write it in the state of New Jersey. If that proposal had become law in the state of New Jersey, it's almost assured that INA would have cancelled its professional liability coverage in the state of Oklahoma, since this is the only state in which it has that type of coverage.

When the New Jersey situation came to the attention of the OSMA, Governor David Boren interceded on our behalf by writing the governor of the State of New Jersey and pointing out how this legislation in his state would affect Oklahomans.

Insurance companies writing professional liability must be sensitive to the difficulties that are being experienced nationally. They are concerned that country-wide trends can affect local programs. Even though Oklahoma has a loss experience that is sound and stable, the national loss trend must be a concern of the INA officials.

Due to a combination of people and circumstances, the loss experience for Oklahoma is very favorable. Because the plan has existed for some years, it has been possible to compose a loss development factor that reflects the "tail" of professional liability insurance in the state of Oklahoma. This has helped make the premiums charged to individual physicians more competitive.

Your Council on Insurance authorized the Insurance Company of North America to request a premium increase for this year. Even with this increase the INA rates in the state of Oklahoma may well be the lowest in the nation. Nearly 2,000 OSMA members purchased this bargain-rate high quality plan. It is hoped that the premium rate can stay stable in coming years, but it must be recognized that malpractice claims and awards have taken a marked upswing across the nation in just the past year.

While Oklahoma appears to be a calm spot in a sea of turmoil, it might be well to touch on a few of the important factors that help preserve the program. Prompt reporting of incidents by individual physicians has helped preserve necessary information and evidence against future malpractice claims. INA's top flight adjusters, the attorneys that the OSMA and INA have jointly chosen to defend physicians, and the spirit of cooperation between the association and the company have been major factors in preserving the program.

Your Council on Insurance, the Executive Staff of the OSMA, the Insurance Counselor for the OSMA and the INA will continue to work together on this valuable and important program. Because of the changing national situation, it will be necessary for us to constantly monitor national trends and, perhaps, to attempt to derive innovative new approaches to this coverage.

In addition, the Council on Insurance has pledged to undertake a vigorous claims prevention program during the upcoming year. We may be in contact with every county medical society asking for a time and place to conduct such a program at the local level.

Report of the
COUNCIL ON PUBLIC POLICY
(APPROVED)

Council Members

M. Joe Crosthwait, MD, Chairman, Midwest City

Homer D. Hardy, MD, Tulsa
F. D. Kalbfleisch, MD, Lawton
Jake Jones, MD, Shawnee
Thomas C. Points, MD, Oklahoma City
Irvin B. Braverman, MD, Tulsa
Edward D. Greenberger, MD, McAlester
Gerald L. Beasley, Jr., MD, Duncan
George H. Garrison, MD, Oklahoma City
Jerold D. Kethley, MD, Shawnee
Tom S. Gafford, MD, Muskogee
Harlan Thomas, MD, Tulsa
James B. Eskridge, III, MD, Oklahoma City
H. E. Denyer, MD, Bartlesville
R. Barton Carl, MD, Oklahoma City
John X. Blender, MD, Cherokee
Duane Brothers, MD, Tulsa
David B. Lhevine, MD, Tulsa
Eugene S. Bell, MD, Tishomingo

State Legislative Committee

R. Barton Carl, MD, Chairman, Oklahoma City
S. N. Stone, MD, Oklahoma City
Karl K. Boatman, MD, Oklahoma City
Robert S. Ellis, MD, Oklahoma City
Royce C. McDougal, MD, Holdenville
John R. Smith, MD, Oklahoma City
Joseph W. Stafford, MD, Enid
Marion C. Wagnon, MD, Del City
George H. Kamp, MD, Tulsa
William L. Hughes, MD, Oklahoma City
James B. Lockhart, MD, Tulsa
Perry Lambird, MD, Oklahoma City
William G. Bernhardt, MD, Midwest City
Edgar W. Young, Jr., MD, El Reno
Worth M. Gross, MD, Tulsa
Alfred H. Bungardt, MD, Tulsa

Medical Heritage Committee

R. Palmer Howard, MD, Oklahoma City,
Chairman
George H. Garrison, MD, Oklahoma City
William R. Paschal, MD, Oklahoma City
Neil B. Kimerer, MD, Oklahoma City
Winifred A. Showman, MD, Tulsa
Clinton Gallaher, MD, Shawnee
E. C. Mohler, MD, Ponca City
B. E. Blevins, MD, Midwest City
Pat Fite, Sr., MD, Muskogee

SECTION I
COUNCIL ACTIVITIES

Your Council on Public Policy is responsible

for several of the Association's most important activities. Public Relations, Internal Communications, Federal and State Legislation are all within the purview of this Council.

The State Legislative Committee is most active and many good doctors are sacrificing a considerable amount of their time on your behalf. The work load has never been greater, nor the legislation more important; they need your help and active support.

Last year, we developed an ambitious Public Relations campaign. We have implemented some of the recommendations you approved. Others, because of other more pressing obligations, have been held in abeyance. They will be put into effect as time and resources are available.

The "OSMA Comment" and the "Journal of OSMA" are our principal internal communications tools. *The Journal*, for similar reasons, reported in the past, still is in financial difficulty. *Comment*, the two-page newsletter, appears to have good readership and because it is quick to produce, offers us the opportunity to communicate with our members quickly. Information on legislative affairs is disseminated through a weekly Legislative Reporter. That publication has a limited mailing list of 200 or so physicians who are interested in State legislation. Any member can be put on the mailing list.

The Association's actions on the Utilization Review regulations are well known and covered in other reports before the delegates. While a reprieve has been achieved, there is evidence that there is more to come. Delegates' action on this critical issue could considerably increase the activities of this Council.

Due to domestic, economic and foreign policy problems, the Congress seems reasonably quiet about National Health Insurance. However, this volatile subject could emerge at any minute.

Jurisdictional battles and funding problems apparently have stymied the implementation of PSRO. The deadline for operational programs is still January, 1976, but planning funds have yet to be released. The future of this program is very confusing. OSMA members will be kept well informed on this subject.

Finally, there is now a move in the Congress to "assist" in the current malpractice insurance crisis. Learned authorities have indicated that the Federal government has a limited, if any, role in the medical liability problem, but, nonetheless, several bills have been filed —

some with major ramifications. It is the current opinion of the Council that professional liability insurance is a state problem and should be handled at the state level. More details on this matter are included in the Council on Insurance report.

RECOMMENDATION:

1. That the activities of the Council be continued.

SECTION II

STATE LEGISLATIVE COMMITTEE

Since the 1st Session of the 35th Oklahoma Legislature is still in session, it is not possible to give the House of Delegates a complete Legislative report. Actions by the Delegates last year aided considerably the efforts of this Committee. The influence of OMPAC in State races has improved our ability to represent the Association at the State Capitol. However, the interest of lawmakers in the business of medicine is ever increasing. Each year we see more and more medical bills introduced. Too, we are faced with problems that require legislative solutions. The net result is a work load of significant proportion. The Committee currently has under scrutiny a total of 99 bills. Some require little effort; others require considerable time, staff and committee work. A few require the cooperation of all Oklahoma physicians. The alarming fact is that the "few" are becoming larger in number, partially because we have initiated more legislation than in past years.

Last year your Council on Public Policy, of which this Committee is a constituent, requested approval of five recommendations. They were:

1. That OSMA continue its policy of assigning one staff member the primary lobbying responsibility.

This policy has been maintained. However, it has been necessary this session to hire additional help on special projects. This process has worked extremely well, and we hope you will approve of such expenditures when they are necessary.

2. That additional financial support be granted for defraying the expense of mass mailings to the membership.

The Committee has notified the entire association membership of pending legislation on one occasion this year, but may need additional assistance before the session ends.

3. That an automatic typewriter be leased or purchased to improve communication.

This has been one of our most effective tools during this session. It is possible to write over one hundred personal letters in one working day. We have communicated with the entire Senate and all of their physician contacts in a matter of hours. Response from Legislators and doctors has been very good. The machine is a Redactron Twin Tape Computer with an IBM Selectric typewriter leased for approximately \$285 per month. We appreciate your approval of this new equipment.

4. Installation, if feasible, of a Watts Line (state) for improved communication.

Initial surveys did not justify the expense of a Watts Line. However, we currently have under review by telephone personnel, our entire system and both local and long distance calls. We expect a report in the near future which may require reconsideration of the Watts Line.

5. Full Support of OMPAC

For the past seven years, because of increased physician support, OMPAC (Oklahoma Medical Political Action Committee) has increased its contributions to candidates for state offices. Their success ratio has been high. Many of the members now serving in the Oklahoma Legislature are recipients of modest OMPAC contributions. It is important that we continue that trend. All OSMA members should be members of OMPAC.

In addition to these requests we suggested that liaison with our medical specialty organizations be improved and expanded. We now have Legislative consultants from seven specialty organizations.

The Ladies Auxiliary sponsored another "Doctors' Wives Day at the Legislature" program. Well over one hundred women attended the half-day program featuring Governor Boren, Legislative leaders and Acting Dean, Thomas Lynn, MD. Auxiliary members have expressed a sincere interest in helping our Committee with its legislative program but, we are still unable to capitalize on this valuable resource. We hope to in the next legislative session.

Physicians serving as Doctor of the Day are certain to recognize the new and improved quarters. The Capitol First Aid Station has been moved to the 3rd floor. We now have two rooms and water, a considerable improvement over previous years. This is still one of OSMA's most successful public relation efforts and we encourage every physician to serve at least once. Necessary backup facilities are available

at the Family Medicine Clinic and University Hospital.

Our Legislative Liaison Committee functions as our "crisis to crisis" committee. Almost 200 physicians who have agreed to contact their legislators at the committee's request receive the *almost* weekly "Legislative Reporter." Staff workload has hampered the regularity of the Reporter. We are now getting requests from Legislators for our weekly publication, an indication of their interest about our opinion on Legislation. Any OSMA member who wants to receive the report can do so by sending his name to OSMA headquarters. Our Committee appreciates the efforts of many members who work on Legislative affairs.

There are many bills introduced in the Oklahoma Legislature that can have serious repercussions on the practice of medicine — bills that affect the physician-patient relationship, bills that would permit acts that are harmful to patients, bills that provoke professional liability actions and bills that affect our medical school. But there are also bills that can improve the quality of health care in Oklahoma, bills that can improve the distribution of physicians, that will help finance medical education for needy medical students, that will eliminate many communicable diseases in our young people, provide insurance coverage for the newborn, help our medical school and aid our attorneys in defending malpractice suits. A summary of the most important bills follows. Specific information or copies can be obtained from OSMA headquarters.

Summary of Bills

HB 1085 – Creating a Separate Board of Regents for OUHSC. This proposal would remove the Health Sciences Center from OU Regents jurisdiction and establish a new, nine member board to govern the Center's four colleges of Medicine, Health, Dentistry and Nursing. This measure received considerable opposition from educators, politicians and the OU Medical School Alumni. The bill is in the House Appropriations and Budget Committee and will probably remain there for the rest of this session.

HB 1104 – Appropriation to the Rural Medical Education Loan and Scholarship Fund. In

keeping with his promise to the Joint Session of the Oklahoma Legislature, the Governor has recommended an increased appropriation for the scholarship fund. If the bill is passed it will be for a total of \$200,000 rather than \$100,000 appropriated in previous years.

HB 1159 – Requiring the Board of Pharmacy to Prepare a List of Drugs. This bill would have required that the Oklahoma Board of Pharmacy prepare a list of the 100 most frequently prescribed drugs together with the two most common quantities in which they are filled and then distribute the list to each pharmacy in the State. The bill was defeated on the floor of the House of Representatives.

HB 1160 – Permitting Pharmacists to Substitute Drugs. This is probably the most controversial bill OSMA was involved in during this Legislative Session. Existing Oklahoma law permits pharmacists to substitute for a prescribed drug with the permission of *either* the prescriber or the purchaser. This law has received considerable publicity in the past two years. It was the opinion of OSMA's Legislative Committee that unilateral substitution was not in the best interest of the patient and that the majority of physicians would want to know if their patient received a drug other than the one prescribed. Representative Hammons' bill as introduced, was not completely acceptable to the Committee, but the basic provisions of the bill did require that the physician have some knowledge of the substitution. We agreed to support Representative Hammons' bill with the understanding that amendments would be accepted requiring that bioequivalency be considered as a primary criteria for drug substitution. The bill was opposed vigorously by representatives of the drug manufacturing industry and by the Pharmaceutical Association. Representative Hammons did not amend the bill as he had agreed to and the bill was voted down in committee on the first hearing by one vote. Later in the session, Representative Hammons introduced a Committee Substitute for HB 1160, which was wholly unacceptable to OSMA's Legislative Committee. We vigorously opposed the bill on the floor of the House of Representatives but it was passed by a narrow margin. It is now in the Senate Committee on Public and Mental Health and will receive a public hearing on the day of the Reference Committee Hearings of OSMA. It is doubtful that the bill will be reported from Committee this session.

HB 1237 – A Revision of Oklahoma's Workmen's Compensation Code. Each year the Oklahoma Legislature considers amendments to Oklahoma's Workmen's Compensation Code with the express purpose to bring the Code more in line with Federal requirements and to change or alter the schedule of payments in keeping with the current salary rates. This year, a provision was put in the bill to restrict medical payments to conform to the schedule of benefits as outlined in the State's Health and Accident Insurance Plan. In other words, the workmen's compensation schedule would be compared to an accident and health insurance policy schedule that does not take into consideration the nature of industrial injuries. At the present time, the bill has passed the House of Representatives and is in a Senate Committee. We have secured the necessary commitments to have the above mentioned provision of the bill removed. However, at this date, the bill has not been reported out of committee as amended.

HB 1307 – Changing population Requirements For Rural Medical Education Loan and Scholarship Funds. At the current time, the State's Rural Loan and Scholarship Fund has a requirement that recipients of the State monies are to practice in a community with the population of less than 5,000 after they graduate and finish their training. This law would raise that population ceiling to 7,500.

HB 1352 – Prohibiting Out of State Students to Enroll in the OU Medical School. This proposal would simply prohibit any out-of-State applicant to be enrolled in the OU College of Medicine. Existing law prohibits the enrollment of more than 20% of any class, however, this percentage has not been reached in recent years. There has been some disenchantment with the admissions policies of the OU College of Medicine, as is evident by other reports before the Delegates. However, it does not appear that this bill will be passed in this session of the Legislature.

HB 1381 – Permitting the Introduction of Printed Matter as Evidence in Civil Actions. The Legislative Committee has reviewed this proposal for several years which would permit any type of publication, learned treatise, etc, to be used as evidence when trying a civil lawsuit. This would be particularly harmful to the defense of professional liability cases and for that reason, we have opposed the bill. It is dead for this Session of the Legislature.

HB 1357 – Granting Minors the Right to Consent for Health Services. This proposal is a modification of a model act recommended by the American Academy of Pediatrics. We have found that there are many problems associated with providing health services to minors. Because of their incapacity to consent for treatment, there are legal problems which sometimes cause the physicians to be reluctant to provide the care. This bill would make it permissible for the physician to provide the treatment without notifying the parents if he so chose but it leaves to his discretion the right to contact parents or guardian. Copies of the bill were mailed to all OSMA members.

HB 1540 – Creating Board of Optical Dispensers and Providing for Licensure. Several times in the past years, OSMA has supported the concept of licensing or certifying dispensing opticians. HB 1540 would create a Board and put them under the authority of the State Board of Medical Examiners. However, the bill did not receive favorable consideration by the Committee and it is being held over until next session. A similar bill is being considered in the Senate, SB 441.

HB 1542 – Providing a Method Whereby a Loan From the Rural Medical Education Loan and Scholarship Fund Can Be Repaid. This bill would permit a recipient of a rural medical education loan or scholarship, the right to repay his obligation to the State by serving in the Oklahoma State Penitentiary. The only means by which a commitment could be fulfilled at the present time is by serving in a community of less than 5,000.

HB 1552–Providing for State Subsidy of Internship and Residency Programs. This legislation has probably consumed more of the Committee's time than any other single bill. It is the result of recommendations made by the Medical Center Liaison Committee and would establish a 15 man commission to analyze the physician need in Oklahoma, the distribution of physicians in Oklahoma, and the training programs for interns and residents and the location of those programs. It would authorize the commission, seven members of whom will be named by the Governor, (the other eight are named in the bill by title), to pay up to 50% of the cost of an intern or resident to an institution that has an accredited program. The bill is very complex since it attempts to deal with the mal-distribution problem, the training of primary care physicians and the location of

training programs. Copies of the bill are available at the OSMA office.

SB 122 – Extending the Statute of Limitations. The existing law permits the claimant two years in which to file a lawsuit to recover damages. This proposal would extend that period of time to three years. OSMA is very much opposed to lengthening the Statute of Limitations because of the impact it could have on our professional liability program.

SB 228 – Permitting Patients Access to Medical Records. This measure would have in its original form, formalized existing common law, inasmuch as it has been ruled by the Court that a patient has a right to information in his medical records. We were concerned about this bill because of the potential problems it posed to physicians and it may be construed by the physician and the patient that the medical record itself, had to be turned over to the patient. The bill was amended to that effect on the Senate Floor and is now in a House Committee. We are making every effort to have the bill amended to read as it was originally introduced or have it killed.

SB 236 – Permitting Claimants Under Workmen's Compensation to Sue For Negligence. Existing Court law protects a physician who renders services to an injured workman covered by Workmen's Compensation. The Court has held that the physician is an agent of the employer and therefore the injured worker's claim is against the employer and not against the physician. This bill would remove that "Halo of Immunity" and could result in a great number of lawsuits against physicians. For that reason, we have vigorously opposed the bill and apparently it will not be passed in the Senate this session.

SB 243 – Providing For The Formation of Health Maintenance Organizations. This is permissive legislation that permits the formation or organization of a Health Maintenance Organization. The regulatory authority is vested in the Health Planning Commission and rules and regulations controlling HMO's would be written by the Commission.

SB 273 – Requiring Health Insurance Companies to Extend Coverage For the Newborn from the Time of Birth. OSMA's Legislative Committee was asked to introduce this bill by the Oklahoma County Medical Society and thus far the bill is progressing well through the

legislative process. Hopefully, it will be enacted this session.

SB 274 – Requiring Basic Immunization for Children in Child Day Care Centers. Existing law requires that before any child can enter a public school for the first time, that he have basic immunization. This measure would simply lower that age to those children that are in Stae licensed child day care centers.

SB 255 – Defining Death. The current law defining death is antiquated and does not permit the flexibility necessary for organ removal and transplantation. For that reason, the Legislative Committee has supported a bill that changes the definition of "dead body" to mean a human body in which there is irreversible, total cessation of brain function; and if based upon ordinary standards of medical practice, during reasonable attempts to either maintain or restore spontaneous circulatory or respiratory functions, it appears that the body cannot be resuscitated. The definition concludes with "death is to be pronounced before artificial means of supporting respiratory and circulatory function are terminated and before any vital organ is removed for purposes of transplantation." The Legislative Committee worked with several consultants on the language of this bill.

SB 278 – Requiring a Certificate of Need For The Development of or Expansion of Institutional Health Services. This legislation would require that before a hospital or major health service institution could expand or be constructed, the developers would have to secure from the State Health Planning Commission, a certificate of need. To conform to recently passed federal law, Oklahoma must enact a certificate of need bill prior to the end of 1976.

SB 312 – Regulation of Emergency Medical Services. Governor Boren, in his address to the Joint Session, emphasized the need to improve Oklahoma's Emergency Medical Services. SB 312 is an effort to provide some regulatory authority over ambulance services and attendants. The bill would give the State Board of Health the authority to write rules and regulations and minimum requirements for emergency services. The Board would be advised by a special Emergency Medical Advisory Committee appointed by the Governor.

SB 398 – Prohibiting the Practice of Acupuncture By Other Than MDs and DOs. The Attorney General has ruled that the Oklahoma Statutes are void as far as the practice of acupuncture is concerned. This in es-

sence means that anyone who wants to can practice acupuncture and quite a few unqualified practitioners are doing so. This bill is an effort to restrict the practice of acupuncture to MDs and DOs. It has been bottled up in the Senate Committee and probably will not be acted upon this session of the Legislature.

There have been a series of bills introduced in the Senate at OSMA's requests. The five bills that deal with areas of professional liability are intended to assist our attorneys in defending medical malpractice cases and also to discourage the filing of cases. The bills are SB 428, SB 429, SB 450, SB 451 and SB 452.

SB 428 provides that a counterclaim for damages for abuse of process in filing may be filed and litigated in the same action when the action is for damages for personal injury or death. In other words, a physician could counterclaim a claimant for malicious or capricious suit and the counterclaim action would be tried along with the malpractice action. SB 429 simply states that unless a physician puts in writing his guaranty or warranty that no action may be brought against him, for a guaranty or warranty. SB 450 would reduce the period of filing a lawsuit from the existing two years to one year and it would also close out any actions after four years of the alleged incident. SB 451 would permit the introduction of evidence about collateral sources available to the claimant. In other words, if the claimant had insurance that paid for some of the damages that he incurred, such as hospitalization, etc., that fact could be made known to the jury. The last bill, SB 452, just instructs the Court under the conditions in which it can invoke the doctrine of "Res Ipsa Loquitur."

There are a considerable number of bills that are not contained in this report that have serious ramifications. These bills are routinely reported in the OSMA Legislative Reporter. If any member of the House of Delegates or member of OSMA would like to be put on the Reporter mailing list, simply notify the OSMA Office.

SECTION III.

MEDICAL HERITAGE COMMITTEE

While your committee has not been active during the past year, it has pledged to begin its 1975-76 functions immediately. It is holding its first meeting during this Oklahoma Medical Summit '75.

Several years ago the OSMA Board of Trust-

ees authorized this committee to use a portion of the basement of the OSMA building for storage of records and artifacts of a historical nature. In reliance upon this pledge, your committee has gathered a small quantity of such items.

A few of these items are on display in the lobby of the OSMA Headquarters Building in a special display case purchased for that function. The remainder, however, are still in storage.

A portion of those items currently in storage will be used, when the opportunity arises to assist the Oklahoma Cowboy Hall of Fame with its Doctor's Office display in the Old Western Town located in the basement of the hall.

Numerous other places were contacted regarding displays, including the Oklahoma Arts and Sciences Foundation and the Oklahoma Historical Society. However, most of these organizations would prefer to have photographs, as opposed to artifacts. While your committee has collected a great amount of material, there are very few photographs included. Anyone having knowledge of the location of early photographs of doctor's offices, hospitals, medical personnel, pharmacies, or even veterinary establishments, are encouraged to contact the committee. The committee has the facilities to have such photographs duplicated and it will not be necessary for it to retain the original photograph for any length of time.

One of the proposals that your committee intends to implement during 1975-76 is that it should serve as a repository for county medical society records. During the past year, the committee offered to receive and store the records of the Pottawatomie County Medical Society.

In order to carry out its intention, the committee will contact each county medical society in the state and offer to receive and store all past records of the societies. In the event the societies prefer to retain their own records, your committee will attempt to arrange for a synopsis of such records to be compiled and forwarded to the state headquarters. Such synopsis to contain not only a general statement of the information contained in the county society records, but also information regarding their location for possible use in the future.

Last year, following a recommendation by the House of Delegates, your committee entered into liaison on medical heritage with the

Oklahoma Pharmaceutical Association, The Oklahoma Dental Association, The Oklahoma Nurses Association, The Oklahoma Hospital Association, and The Oklahoma Veterinarians' Association. All of the organizations indicated their desire to enter into such liaison, and provided the OSMA Medical Heritage Committee with the names of persons to contact.

During the next year, it is the desire of the committee to actively pursue this liaison in an attempt to establish a coordinated effort by all of the organizations to preserve the records and artifacts of Oklahoma's Medical Heritage.

Report of the
FINANCIAL AID TO
EDUCATION COMMITTEE
(APPROVED)

Lucien Pascucci, MD, Chairman, Tulsa
Ed L. Calhoon, MD, Tulsa
Stanley R. McCampbell, MD, Oklahoma City
Jack L. Richardson, MD, Tulsa
Arnold G. Nelson, MD, Midwest City

The Association's dues structure includes a five dollar per member contribution to a Fund that provides financial assistance to medical students. Thus, each year this committee has approximately \$10,000 to be used according to the By-Laws of the Loan and Scholarship Fund, Inc. for loans, scholarships, grants, etc. Since the Fund was established in the late 1950's, Oklahoma physicians have loaned or given needy medical students almost \$105,000. In addition, a resolution passed by the House of Delegates in 1972 solicits a contribution of \$10 from each member of OSMA. The money goes to a fund managed by the Dean of Student Affairs. Since the resolution passed, Oklahoma doctors have given in excess of \$10,000. The total, \$115,000 is a solid refutation of any suggestion that physicians are not interested in medical students and in training more doctors.

Contrary to the belief of some, most medical students enrolled in school today require some type of financial assistance. Not only have tuition and other direct schooling costs risen, but students are as subject to the inflationary pressures as others. The average cost of a year in medical school has risen to \$4,850 as compared with \$3,450 in 1969.

It is imperative that we continue to support

our Medical School. Some health manpower bills introduced in Congress would require severe commitments from Medical Schools before capitation grants can be received and the conditions on graduates are almost as onerous — approaching involuntary servitude. If our state-supported institutions are required to rely on Federal dollars alone, we lose even more control of medical education.

Since 1970, the Board of Directors of the Oklahoma Loan and Scholarship Fund, Inc. (five immediate Past Presidents of OSMA) has transferred its annual income to the Oklahoma Foundation for Community Medical Care. These transfers are in keeping with the House of Delegates directives of that year to direct our monies into programs that will increase the number of doctors in rural Oklahoma. The Foundation has filed a separate report with the House.

The Committee feels the Fund is carrying out the wishes of the House of Delegates and we will continue to do so as long as we are accomplishing our objectives or are given new instructions by the House of Delegates.

Report of the
MEDICAL CENTER LIAISON COMMITTEE

Committee Members

C. S. Lewis, MD, Chairman, Tulsa
Oliver H. Patterson, MD, Sapulpa
Billy Dale Dotter, MD, Okeene
James W. Murphree, MD, Ponca City
G. Rainey Williams, MD, Oklahoma City
James V. Miller, MD, Ardmore
Frank H. Austin, MD, Lawton
Orange M. Welborn, MD, Ada
Kenneth W. Whittington, MD, Bethany
Howard P. Mauldin, MD, Oklahoma City
Robert S. Ellis, MD, Oklahoma City
Jack Parrish, MD, Seminole
M. Boyd Shook, MD, Oklahoma City
Earl M. Bricker, MD, Oklahoma City
Curtis B. Cunningham, MD, Clinton

The bleak conditions existent at the Oklahoma Health Sciences Center eleven months ago have faded with winter weather. A turnaround has taken place. University and Center officials can look back over the arduous pursuits of the past with substantial pride. Likewise, Association members can lay partial claim for the progress made. Just a few months ago we had faculty resignations of major pro-

portions — today our faculty is confident and growing; a year ago, it appeared University Hospital was destined for padlocking — today it is solvent and expanding. The 34th Oklahoma Legislature viewed OUHSC with disdain — The 35th Oklahoma Legislature has been very generous to the Center. These conditions did not change without cause and your Medical Center Liaison Committee played a major role in the changing attitude toward the Center.

Faced with the crises mentioned above, OSMA President, Jack Richardson, MD, initiated a series of meetings with Center and University officials. With the help of Committee members, the major problems of OUHSC were isolated. Meeting after meeting resulted in a refined program for trustee consideration as follows:

Objective:

The objective of the project is to realize higher levels of state funding of medical education through the Legislature by creating a broader understanding of and appreciation for medical education excellence in the State of Oklahoma.

Target Audiences:

To achieve its objective, OSMA will concentrate a mass communications program toward three primary target audiences: members of OSMA, members of and candidates for the State Legislature, and the lay leadership of key cities throughout the state. A secondary audience will be the general public.

Timing:

The project must be conducted as soon as possible after the state primary elections (August 27) and completed before the next Legislative session begins.

Strategy:

The basic strategy is to present the story of medical education in community meetings with legislators and local leadership present which will apply pressure of the constituents upon the legislators to properly support medical education programs.

Communications Vehicles:

The basic communications vehicles to be used are (1) a 10-12 minute slide presentation, (2) a brochure which capsulizes the content of the slide presentation, (3) newspaper publicity.

Implementation:

Target date for completion of the slide presentation and brochure is September 15. OSMA will select and arrange for meeting locations, dates, staffing, etc.

Key Issues:

There are several key issues in this project which will be highlighted in the materials. These include:

(1) Does Oklahoma have enough physicians and other health manpower? Do we have the capacity to produce what we need?

(2) Do we have the ingredients for producing excellence in medical personnel . . . faculty, facilities, finances?

(3) Are we producing the right amount or the proper kinds of physicians? Are they staying in Oklahoma, and, if so, where?

(4) Are Oklahomans willing and able to pay for better health care? If so, how?

(5) How does University Hospital relate to quality health care for all Oklahomans?

(6) If you want more and better health care for your family and all Oklahomans, what can you do about it?

Approval by the Trustees resulted in the presentation "Medical Education — Who Cares? Special Report" (Copy in Delegates Folder).

In August the President and the Committee Chairman held a press conference and announced our intent to aid the Health Sciences Center. The press release received broad coverage plus favorable editorial comment as did the conference with TV and Radio Stations. In essence, the release covered these points:

1. Financial problems at OUHSC did not occur overnight;

2. That financial problems had been ignored too long by the legislature and Center officials;

3. That mutual distrust contributed to the problem;

4. That management of the Center must be responsible and accountable;

5. That lack of foresight on the part of political leadership caused the prolonged crisis;

6. That the lack of a plan to care for the medically indigent was robbing the Center of educational funds; and

7. The OSMA leaders called upon the citizenry and elected leaders to support the Center.

The Committee adopted an ambitious schedule for presenting its program. Fifteen communities were selected and with the help of local coordinators, volunteer faculty and committee members, the bulk of the sessions were conducted in a span of thirty days. As nearly as possible speaking teams with representatives of OSMA, the Committee, OUHSC and University Hospital were sent to each location.

The exact number of community leaders, politicians, media representatives, Chamber of Commerce officials, etc., who attended is difficult to estimate. However, we are sure that more than a thousand have seen the presentation (the presentation has been given many more times than the fifteen officially conducted by OSMA).

The results have been encouraging. There is a new confidence in the Center. Not all the problems have been resolved, but there is a cooperative attitude about solving them. Governor Boren has been most cooperative and supportive of the Center, honoring a commitment he made during the campaign. The Legislature has indicated they will assist by supporting with State funds, internship and residency programs. Too, the appropriation for the Rural Loan Program will be doubled if pending legislation is passed.

Recently, the New Provost of OUHSC, William Thurman, MD, took charge of his position, adding additional stability to the Center.

In summary it appears we have turned the corner and the future is bright.

During the year, perhaps because of the Center's problems and our involvement, a new relationship with the medical school faculty developed. Faculty members who attended the presentations received new insight about attitudes toward the Center. Likewise, non-faculty physicians came to a better understanding of the faculty members' problems. To continue that dialogue and to preserve and expand the newfound relationship, the Faculty Board created a Committee on Extra-Mural Relations. The Committee is functioning well and some of the results are evident at this meeting — the OUHSC Faculty Board Reception. In addition, the Dean of Student Affairs has been requested and has agreed to serve on this Committee. In 1976, the Center will host a function at the AMA Annual Meeting for OSMA Officers, Delegates and OU Alumni who may be attending the meeting. The Committee was also instrumental in arranging faculty hosts and medical displays for a legislative reception held April 14.

Students, Interns and Residents have demonstrated interest in the Association program and we have maintained liaison in various ways. Medical students have developed a program for Summit—a first time occurrence—and at various times during the year have of-

fered to assist us in our educational campaign. Residents' wives are conducting OUHSC Tours during the Summit meeting on Thursday and Friday.

In previous years the Association managed summer work projects for medical students. This year, because of more pressing demands, the Summer employment program is coordinated through the Oklahoma Council for Health Careers. For information contact Oklahoma Council for Health Careers, 715 N.E. 14th, Oklahoma City, Oklahoma 73104.

A recent problem, upon which the Committee has not acted, is an attempt by Oklahoma lawmakers to legislate the composition of the OU College of Medicine's Admissions Board. Senate Joint Resolution 22, authored by Al Terrill, Senator from Lawton and Representatives Davis and Beznoska, also of Lawton, would require that the Board be composed of five members from the Administration and Staff and one member to be selected by the County Medical Society from each of the 24 Judicial Districts in Oklahoma. Within the past few days we have been informed that the authors of the Resolution would accept amendments changing the language so that two physicians would be selected by the state medical societies from each of the six congressional districts. The Committee is polling members by mail for their opinion of the proposal and hopefully we can report to the reference committee and the Delegates. OSMA's Legislative Committee has taken a position of opposition to the bill as originally introduced. They are attempting to meet with legislative leaders.

To agree to a legislated admissions board could set a bad precedence. Similar infringements could be enacted on all Oklahoma professional schools, in fact, all state-supported schools. Secondly, to agree to either of the proposals is an admission that the existing process is inequitable — a fact not supported by recent acts of this Committee. While we have had differences with the school in past years, we have helped in developing the existing system that allows for recommendations to the Board from the Oklahoma State Medical Association and the Oklahoma Academy of Family Physicians. We have insisted that 50% of the Board be composed of practicing physicians. The current Board has 20 practicing physicians and four full-time faculty members. There are also 9 medical students serving. Our members have disagreed about the wisdom of

students serving in the selection process and questions have been raised about the number of out-of-state students admitted.

Because of the controversy on this issue, the Committee Chairman has agreed to co-author a Resolution with the Chairman of the Legislative Committee requesting a study of the OU College of Medicine's admission policy and the effect of that policy on the distribution of physicians in Oklahoma. This Resolution should not be construed to be critical of the selection process, only to recognize that a study could allay concerns and result in constructive recommendations.

RECOMMENDATION:

1. That activities of the Committee be continued.

Report of the CONSTITUTION AND BYLAWS COMMITTEE (APPROVED)

Committee Members

George H. Garrison, MD, Oklahoma City,
Chairman
E. N. Lubin, MD, Tulsa
Arnold G. Nelson, MD, Midwest City
Paul H. Rempel, MD, Enid
Clinton Gallaher, MD, Shawnee
Leo E. Yates, MD, Oklahoma City

The bylaws of the Oklahoma State Medical Association provide that the Constitution and Bylaws Committee has the responsibility of studying amendments to the bylaws and constitution as proposed by members of the association or by component societies. In addition, your committee may originate amendments to the constitution and bylaws, if it so desires. In either case, the recommendations of the committee are to be forwarded to the House of Delegates for final consideration and action.

Your committee is aware of only one move to amend the bylaws of the association, and that is the recommendation that American Medical Association membership be removed as a requirement for OSMA membership. In other words, the recommendation has been made that AMA membership be made voluntary in the state of Oklahoma.

The question as to whether or not the AMA membership requirement should be changed has arisen numerous times in the past. On each of those occasions your committee has de-

termined that it did not wish to take a stand on the issue, but simply recommended the wording to be followed by the House of Delegates if it chose to remove this requirement. The committee will follow the same procedure this year.

If the House of Delegates determines that it wishes to drop the mandatory AMA requirement, the constitution and bylaws committee recommends that it adopt the following word changes in the OSMA bylaws: Amend Chapter I, Section 1.00, of the bylaws by deleting the entire last sentence of the section. All of the wording, with the exception of the section number and the title of Chapter II, Section 2.00 should be deleted, and the following wording inserted in its place: "Members of this association who elect to become members of the American Medical Association, shall pay AMA dues and assessments as levied for their appropriate classification of membership. AMA dues and assessments should be collected and remitted by component societies in like manner as state association dues and assessments."

Chapter V, Section 7.036 should be amended by inserting the words ". . . involving AMA members . . ." to make the first sentence of that section read, "Judicial decisions of the Board of Trustees *involving AMA members* may be appealed to the Judicial Council of the American Medical Association in accordance with that organization's constitution and bylaws."

Further, in the event the House of Delegates chooses to make AMA membership voluntary, your committee recommends that all county medical societies be instructed by the House of Delegates to amend their bylaws accordingly.

Your committee must make three recommendations for changes in the constitution and bylaws. They all take the form of "house cleaning" amendments to correct oversights from previous years.

Last year, the House of Delegates amended the section of the bylaws designating the association's "general officers." It neglected to amend that portion of the constitution designating the general officers. Your committee recommends that the constitution of the State Medical Association be amended as follows: Article VIII, Section 1, be reworded as follows, "The general officers of the association shall be the president, president-elect, immediate past-president, vice-president, secretary-treasurer, speaker of the House of Delegates, vice-speaker of the House of Delegates, and

chairman of the Board of Trustees." Section 2 should be reworded to read as follows: "General officers shall be elected by the House of Delegates at its annual meeting, with the exception of the immediate past-president who shall remain as an officer in this capacity for a period of one year following the completion of his term as president and *with the exception of the Chairman of the Board of Trustees, who shall be selected by the Board.* The House of Delegates may remove any general officer from office for cause."

The other change in the bylaws involves the new method being followed in conducting the OSMA's annual meetings. Now that the association is holding meetings in conjunction with the Oklahoma City Clinical Society and the Oklahoma Academy of Family Physicians, it can no longer meet the technical requirements of its own bylaws dealing with annual meetings. Therefore, your committee recommends that Chapter III, the Annual Meeting Section of the OSMA bylaws, be repealed in its entirety and replaced by the following language:

"Section 1.00 TIME. The Annual Meeting of the OSMA House of Delegates shall be held at least 30 days prior to the Annual Meeting of the American Medical Association. The precise dates for the annual meeting shall be recommended by the OSMA Board of Trustees."

Chapter IV, Section 3.01 should be repealed and replaced with the following language: "3.01 ANNUAL MEETING. The House of Delegates shall conduct its annual meeting at the time and place selected by the OSMA Board of Trustees in compliance with Chapter III, Section 1.00."

Chapter X, Section 1.00 should be amended to delete "annual meeting committee" and add, in its place, "scientific assembly committee."

Section 2.00 of that Chapter should be amended to read as follows: "Scientific Assembly Committee." The Scientific Assembly Committee shall consist of at least six members, appointed for staggered terms of three years each by the president.

"2.01 DUTIES. The Scientific Assembly Committee, with the approval of the Board of Trustees, shall work with all other interested medical and allied health organizations to arrange for joint meetings of a scientific and medical nature. It shall be responsible for assisting in the planning, conduct and publicity

of such programs, and for the planning and conduct of other related events and functions not otherwise assigned to other association committees and officers. The committee may request the president to appoint special committees or advisory groups to assist in the proper conduct of its program."

The above outlined changes in the bylaws will allow the OSMA to continue participating in Oklahoma Medical Summit without being in technical violation of its own bylaws.

Report of the
COUNCIL ON CONTINUING
MEDICAL EDUCATION
(APPROVED)

Council Members

Kenneth Whittington, MD, Bethany, Chairman

Royce B. Means, MD, Lawton

Ralph L. Buller, MD, Hydro

Clarence P. Taylor, MD, Ada

John W. Drake, MD, Oklahoma City

James C. Smith, MD, Tulsa

John A. Blaschke, MD, Oklahoma City

Wendell L. Smith, MD, Tulsa

Irwin H. Brown, MD, Oklahoma City

David E. Browning, Jr., MD, Tulsa

James F. Tagge, MD, Enid

James D. Loudon, MD, Shawnee

Y. E. Parkhurst, MD, Norman

Jack W. Parrish, MD, Seminole

William E. Dalton, MD, Oklahoma City

During this meeting last year, your council polled Oklahoma physicians to determine the type of medical education programs that would be of most interest. We are now analyzing the results of another survey asking the acceptability of the Higher Regents Televised Instruction System as a media for continuing education.

The survey run during Summit last year indicates that physicians prefer scientific programs over socioeconomic subjects. However, most stated that they would send office personnel to sessions on coding, billing and collecting Medicare-Medicaid problems and Use of Relative Value Studies. Your council chairman, and an OSMA staff member attended a commercial course sponsored by the Oklahoma Society of Internal Medicine which covered many of the subjects mentioned above. Using a similar program format and with the help of

medical assistants, a course has been designed for physician office personnel. The course has been taught once and two others are scheduled in May. The first course was oversubscribed. A tuition fee is charged to defray all expenses connected with the course.

Summit '75's scientific program, though not directly related to the survey, is an attempt to answer the need for special medical education. Thirteen medical specialties are participating in this program, the highest ever; in addition, medical organizations such as the Medical Research Foundation, Oklahoma Heart Association and the Oklahoma Cancer Society are conducting scientific sessions. A total of seventy-two accredited hours will be offered during the three-day affair.

Council representatives attended the Fourth Biennial Conference on Continuing Medical Education for State Medical Associations and Specialty Societies sponsored by AMA. Conferees spent two days discussing in detail the need to qualify evidence of a physician's continuing competence to practice his profession. In other words, how can the physician demonstrate his ability to practice good medicine, self-assessment, re-certification, specialty testing and re-licensure were explored. In general, the Conference concluded that continuing medical education is essential to good medical practice; that medical societies should make efforts to encourage participation in good scientific programming; that primitive measures were not incentives for participation; that re-certification might be a good idea but there were significant problems in implementation and finally, while most conferees felt some continuing education requirements for membership in State Societies, most rejected the idea of a specific requirement for membership in AMA.

The quality of continuing medical education has been under scrutiny for a number of years. AMA has developed a plan for accrediting State Associations who in turn accredit programs conducted by state, local or specialty units, ie, hospitals, specialty societies, clinical societies, etc. Thirty-three states have been approved as accrediting bodies. Your Council, to date, has rejected this idea. Most of the formal post-doctoral medical education in Oklahoma can be accredited by the Department of Continuing Medical Education for Physicians, OUHSC. We have discussed, on several occasions, the propriety of seeking accreditation status with Irwin Brown, MD, Director of the

department. We feel it would be an unnecessary duplication of effort at this time. Our Council works closely with Doctor Brown and the Medical Center. Plans have been completed for the co-sponsorship of some programs and others are in the offing. Current programming by the Department offers a variety of medical education in different specialty interests and locations. There are sincere efforts to broadcast courses over the talk-back television network but there are mechanical problems involved, not the least of which is confidential, since the network involves forty-five satellite stations in institutions and industrial complexes.

The college of medicine has agreed to develop a special assistant program for physicians. Hopefully, a plan can be designed to provide the latest information on a particular subject to an individual physician upon telephone request. Basically, a call to the Department of Continuing Medical Education requesting information would be channeled to a particular faculty member who would call the requesting physician. The faculty physician would survey the available information and direct the staff of the department to send appropriate information along with suggestions for reading. It is possible that this type course work can be accredited. However, mechanisms for assessment and financing must be established.

The Council will continue its efforts to make certain that Oklahoma physicians have the opportunity to enroll in quality continuing medical education programs at the local, regional and state level. We will avail ourselves of all resources, both private and governmental to accomplish that goal. However, it is the opinion of the Council that these programs should be self-supporting.

RECOMMENDATIONS:

1. That the House of Delegates urge all OSMA members to maintain their medical competence through continuing medical study.
2. That all members be urged to work toward AMA Physicians Recognition Award.
3. That the activities of the Council be continued.

Report of the COUNCIL ON PROFESSIONAL AND INTERVOCATIONAL RELATIONS (APPROVED)

Council Members

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Bryce C. Bliss, MD, Tulsa
Marvin K. Margo, MD, Oklahoma City
Kenneth G. Lowe, MD, Poteau
Don F. Rhinehart, MD, Oklahoma City
Orby L. Butcher, MD, Oklahoma City
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David P. Mitchell, MD, Madill

Medical-Legal Relations Committee

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Samuel O. Jack, MD, Lawton
Richard G. Dotter, MD, Oklahoma City
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Tim K. Smalley, MD, Stillwater
Lowell N. Templer, MD, Altus
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Attorney Members

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Holland Meacham, Elk City
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Howard K. Berry, Jr., Oklahoma City
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Ed Kelsay, Oklahoma City
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T. D. Nicklas, Lawton
William Dale Reneau, Oklahoma City
James E. Poe, Tulsa
Jefferson Greer, Tulsa
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Claim Men's Liaison Committee

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Orange M. Welborn, MD, Ada
James P. Bell, MD, Oklahoma City
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Medical-Dental Liaison Committee

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Howard P. Mauldin, MD, Oklahoma City
Ed L. Calhoon, MD, Beaver
Kent Braden, MD, Oklahoma City

Kenneth Whittington, MD, Bethany
Don Blair, Oklahoma City, ex-officio

SECTION I.
THE COUNCIL

By necessity, the Association must maintain relationships with a variety of professional and allied organizations. At times, these relations become almost adversary, most of the time they are amicable and result in a combining of talent to accomplish a common objective. All of the time they are maintained to facilitate open communication and a forum for free discussion.

Fortunately, the vast majority of this Council's activities can be handled by able committee chairmen and staff. We can enter into common education programs with nurses without formal Council meetings, we review the problems in our Workmen's Compensation system without committee hearing. We work with Pharmacists and Osteopaths in an ongoing manner. Thus, the Council, while maintaining its liaison commitments does not have to meet except in those unusual situations where extreme problems arise. While the past year has been relatively quiet, there is every reason to believe the Council will have to face major issues in 1975-76. The reports of Committee Chairmen reflect major problems in the area of cults and quackery and optometry. The Council requests that special attention be given to the report of the Claim Men's Liaison Committee efforts to improve the working relationship between physicians and representatives of third party payors deserves careful consideration by the House of Delegates.

A review of the Council's areas of concern are as follows:

SECTION II
MEDICAL-LEGAL RELATIONS
COMMITTEE

Your committee has met several times during the past administrative year. Its primary function occurred July 18-21 when it conducted the 1974 Medical-Legal Institute at Fountainhead State Lodge on Lake Eufaula. 220 physicians and attorneys attended the three-day meeting.

The Medical-Legal Institute is held every two years. The 1976 Institute has been scheduled for June 18-19 at Shangri-La Lodge on Grand Lake.

During the past year your committee was asked to prepare a statement on preserving patient medical records. The committee recommends that the following statement be adopted as a part of this report:

"The Oklahoma State Medical Association House of Delegates recommends that complete patient medical records be retained in their original form, for a period of six years, and in either the original or a reproducible form (ie, such as microfilm) for ten years after the most recent patient care usage. After this period, such records may be destroyed unless destruction is specifically prohibited by statute, ordinance, regulation or law.

"The general recommendation may be followed, with the following exceptions: physicians are urged to retain complete medical records of minors for the period of minority, plus two years, and they are urged to retain complete medical records of patients under mental disability in like manner as those of patients under disability for minority, and retain complete patient medical records for longer periods of time when requested to do so by one of the following: an attending or consultant physician of the patient, the patient or someone acting legally in his behalf, or legal counsel for a party having an interest affected by the patient medical records.

"Physicians are further urged to retain all medical records which reflect an untoward incident or an unexpected result from a surgical or medical procedure."

The adoption of the above patient record preservation statement should allow many physicians to relieve, to some extent their record storage problem.

During the past year your committee has attempted to adjudicate a number of grievances involving both physicians and attorneys. In each instance the committee relied upon the code of interprofessional conduct adopted by the OSMA House of Delegates and the Oklahoma Bar Association's House of Delegates several years ago. The code has proven to be a very workable document of great value to both professions.

SECTION III CLAIM MEN'S LIAISON COMMITTEE

During its 1973 meeting the OSMA House of Delegates authorized the creation of the Claim Men's Liaison Committee in order to establish

a direct relationship with the Oklahoma Claim Men Association. That instruction was reiterated by the House of Delegates in 1974.

In the last year your committee has worked with the Oklahoma Claim Men Association to devise the following proposed "guidelines for understanding between physicians and claim representatives."

Your committee urges the House of Delegates to adopt these guidelines as written, but at the same time to instruct your committee to continue negotiations with the claim representative organization to create an even better document.

The major difficulty faced by your committee in working with the Oklahoma Claim Men Association is found in the fact that these men are employees of large insurance companies. While they are attempting to upgrade their own profession, they cannot speak for the companies that employ them. If the company has a policy that is contrary to any code or guideline, the claim representative must abide by his company policy. Therefore, your committee has found it necessary to write a guideline in very broad and generalized terms. This is sometimes repugnant to us, since there are specific things we would like to include, but these would require formal concurrence by the individual insurance company.

Your committee does hasten to point out, however, that the guideline as written is a good working document that can be utilized by our profession whenever dealing with an insurance claim representative.

The guideline is as follows:

Guidelines for Understanding Between Physicians and Claim Representatives

The purpose of this guideline of understanding is to improve relations between doctors of medicine and insurance claim representatives. Its provisions are intended as guides for physicians and claim representatives in the mutual desire to see that nothing in their relationship is detrimental to the interest of the patient.

This guideline of understanding is not a pronouncement of law, but constitutes suggested rules of conduct for members of these professions, each subject to the principles of ethics governing their respective members.

This guideline recognizes that doctors of medicine and members of the claims profession have areas of mutual responsibility and concern. It is hoped by those that have partici-

pated in the development of this guideline that by an improved relationship between the professions of medicine and claim handling, the public will be better served.

Basic Considerations

The physicians may be involved in the following doctor-patient relationship:

- (1) Where the private patient is not covered by any type of insurance protection.
- (2) Where the patient is covered by governmental third parties.
- (3) Where the patient is covered by individual or group coverage.
- (4) Where the patient is involved in a liability situation.
- (5) Where the patient is covered by the workmen's compensation act.

This guideline will deal to whatever extent is necessary with all of the above relationships except the first (where there is no insurance coverage involved.)

Governmental Third Party

Since the payment portion of the physician-patient relationship in such cases is controlled by federal regulation, and few insurance companies are involved in these coverages, it is felt that this guideline should leave any unusual problems to resolution between the physician and the fiscal intermediary involved.

Individual or Group Coverage

In this category fall those cases involving Blue Cross and Blue Shield, as well as those illnesses and accidents directly covered by private insurance. The insured has the obligation to report the covered loss in writing to the carrier within the time set out in the policy contract. The insurance carrier then furnishes claim forms with portions to be completed by the attending physician and the insured patient. Although the paperwork in such claims is substantial, misunderstandings are not common in this area.

Liability Situations

All such cases involve the physician-patient privilege relationship. The physician always should require medical authorizations signed by the patient before discussing any such case with a claim representative or releasing any information to a claim representative. The claim representative should always furnish signed authorization in such cases. He should protect the physician's bill where possible, when furnished with assignment of interest. He should expect to pay a reasonable fee for

any report requested. The fee should be discussed and agreement reached as to the amount. Misunderstandings in this area often can be avoided if arrangement can be made for a short personal conference between the physician and claim representative, particularly where they are not already personally acquainted. The claim representative should not appear at the physician's office unannounced, but after he makes the indicated contact through the physician's appointment desk, the physician should make an effort to see him promptly at the appointed time, since he, too, has many contacts which must be made during the course of a working day.

Workmen's Compensation Cases

Treatment of industrial injuries and occupational diseases is a special, but not exclusive province of the industrial physician. The relationship of physician to claim representative is established by the specific provisions of the workmen's compensation act. The section of the act dealing with medical treatment requires that the employer promptly provide such medical, surgical or other attendance or treatment as may be necessary after the injury. The attending physician shall supply the injured employee and the employer with a full report of injuries found at the time of examination and proposed treatment, this report to be furnished within seven (7) days after the examination. Also, at the conclusion of the treatment, the attending physician shall supply a full report of his treatment to the employer of the injured employee. This statutory obligation removes the privilege from the physician-patient relationship.

The workmen's compensation insurance carrier should furnish to the attending physician either the Statutory Form 4, "Attending Physician Report" form, or the nationally approved "Surgeons' Report" form for completion in all cases. In cases not involving permanent disability, the only other report generally required is the "final report and bill." Particular attention should be given to answering those questions as to when the patient is able to return to work and whether permanent disability is involved.

It should be noted that permanent disability evaluations are based on the statutory schedule of compensation with reference to the performance of ordinary manual labor and are not necessarily based on impairment of function.

Mutual Understanding

Claim representatives are proud of the fact

that professional standards are now set for them and established by examinations administered through the office of the State Insurance Commissioner. This guideline of understanding with the Oklahoma State Medical Association is further evidence of the increasing professionalism of the claim industry. The profession of medicine and the profession of claim representatives reciprocally acknowledge the foregoing obligations of conduct and understanding.

Permanent liaison committees should be established by both professional groups. Any conduct or practice by a physician or claim representative which might be of concern to the other profession should be called to the attention of that liaison committee as soon as possible, so that it can determine whether disciplinary action might be indicated. Hopefully, any misunderstanding which might occur could be resolved by the joint liaison committee of the two associations.

Your committee acknowledges that the above guidelines are imperfect and require more work. It pledges to work with a committee of the Claim Men's Liaison Organization to perfect the guidelines during the next year. The fruits of its labor shall be brought back to the House of Delegates in 1976.

SECTION IV MEDICAL-DENTAL RELATIONS COMMITTEE

In 1970 the officers of the Oklahoma State Medical Association and the Oklahoma Dental Association determined that it would be beneficial to both organizations to have a joint liaison committee. Five members from each organization were selected to serve by virtue of the positions they held in their respective organizations. It was felt that the Dental and Medical Associations could have joint interests in education programs, peer review, political action, rural medicine, public relations and problems associated with the delivery of health care.

During the past four years the committee has had sporadic activity. While a few problems of mutual concern did surface, most of them were handled at the staff level with very little difficulty. Although the committee did not meet during the last year, it does provide an appropriate mechanism to be utilized in the event a joint problem does arise.

SECTION V CULTS AND QUACKERY

Last year the Council requested that a Cults and Quackery conference be conducted in Oklahoma City to draw attention to the charlatanism of unethical practitioners. We have seen considerable abuse in the past in areas of weight reduction, and more recently abuses in the so-called "practice" of acupuncture. Representatives of the Association met with members and staff of AMA Council on Cults and Quackery and tentative arrangements were made for a conference in the fall of '74 or winter of '75. The Cult and Quackery Council (AMA) planned to hold a meeting in Oklahoma City. We planned to capitalize on the Council talent thereby reducing expense to OSMA for out-of-town speakers. Due to severe cut-backs in AMA's budget, the meeting could not be finalized and because no definitive program had been designed with clear cut objectives, the conference was abandoned.

OSMA's Legislative Committee has secured authorship of a bill that would restrict the use of acupuncture to MD's and DO's under rules and regulations promulgated by the Commissioner of Health. They also plan to have introduced legislation that would require all practitioners of the Healing Arts to be graduates of schools recognized by a national accrediting office. Perhaps a conference could be planned, designed to garner public and legislative support for the passage of these issues. There is no doubt that the curtailment of charlatan practices is dependent upon public sentiment. We still feel that quality health education is the answer to much of this exploitation. Physicians, cast in the role as the "favored" can never eradicate cults by themselves.

SECTION VI NURSES

The Association maintains a continuing liaison with the Oklahoma Nurses Association. They participate in our "Doctor of the Day" program by furnishing a volunteer nurse each day during the legislative session. We have co-sponsored special continuing education programs for nurses, and physicians' representatives of the Association's work with a local committee on the National Joint Practice Commission. The second National Conference on Joint Practice is scheduled late this year in Chicago.

NJPC is an interprofessional organization to improve health care and was established by the AMA and ANA. The primary objective of NJPC is to encourage greater cooperation between physicians and nurses.

The Nurses Association has under study now a possible program that would provide special training for nurses who would agree to gather evidence in circumstances of alleged rape. Conferences have been held with representatives of the District Attorneys Association, OSMA, officials at OUHSC and several Judges. There are questions about the quality of the testimony, the propriety of having nurses fill this role and the extent treatment can be provided. However, OSNA's interest in this problem is an indication of their willingness to assume additional responsibilities.

SECTION VII OCCUPATIONAL MEDICINE

It would be pleasant to report that the Association has made some progress in solving occupational medicine problems. Last year representatives of OSMA met with business and industrial leaders in attempts to reach a consensus on solutions that may have impact on workmen's compensation insurance rates and Industrial Court awards. Those efforts proved to be fruitless.

Oklahoma's workmen's compensation system is one of the poorest in the United States. Business and labor have been unable to reconcile their differences and reach any compromises that would result in improvement. We continue to have one of the highest rates in the nation and lowest benefits. Physicians are caught in the middle of the dilemma by being responsible for medical reports that are used in adversary proceedings. Recent publicity about the Blackwell Zinc and Smelter Company indicate the problems and bring unwarranted criticism to the profession. The Oklahoma Legislature has included in one workmen's compensation bill pending, provisions that would require a fixed schedule for medical services paid for by workmen's compensation insurance. While this provision will probably be deleted from the bill, it again points up the disenchantment of some with the present system.

It is difficult for the council to make any recommendations about workmen's compensa-

tion. We have offered our services to all those who are in a position to rectify the wrongs. About all we can do is continue to do so and hope that needed changes will be made.

SECTION VIII OPHTHALMOLOGY-OPTOMETRY

The Association finds itself in a real dilemma with relation to the profession of Optometry. A lawsuit brought by the Board of Optometric Examiners against a dispensing Optician in Shawnee has resulted in a Court ruling that, among other things, would prohibit opticians from using a keratometer or ophthalmometer. The ruling by the Court of Appeals is being appealed to the Supreme Court. If the Supreme Court takes jurisdiction, OSMA will file an amicus curiae brief as authorized by the House of Delegates last year. We have recently, through OSMA's Legislative Committee contacted Ophthalmologists about the lawsuit and the Court ruling to determine what impact it could have on their profession if the ruling is allowed to stand. It is anticipated that some decision will be made during the Summit meeting by Ophthalmologists.

A long term solution to the problem is either licensing or certification of dispensing opticians. This legislative solution, unless compromises can be worked out with the Optometrists, would be a very difficult task. A bill has been introduced and is being reviewed by Ophthalmologists' consultants, but there is little chance it will be acted on this session of the Legislature.

SECTION IX GENERAL

The Association maintains liaison with the professions of Osteopathy and Pharmacy through other committees and organizations than this Council. The by-laws for the Foundation for Peer Review have been changed to accommodate representation by the Osteopathic profession. Through the Board of the Foundation and through the staff of both organizations, continuing dialogue is maintained. We have worked with OOA on several legislative issues, most notably the Drug Substitution Bill (HB 1160, see Legislative Committee Report) and the Internship and Residency Bill (HB 1552). We have no significant problems to report.

Some pharmacists in the State (as well as

some physicians) misinterpreted the Association's position on drug substitution. A full report is contained in the Legislative Committee's Report (HB 1160). We have an excellent relationship with the Pharmacists of the State and jointly we have worked to alter rules and regulations promulgated by the State Board of Narcotics and Dangerous Drugs. We have also assisted the Pharmaceutical Association in the formation of the plan to implement the drug vendor program authorized by the Oklahoma Legislature and administered by DISRS.

SECTION X RECOMMENDATIONS

This is an informational report to the House of Delegates but it reflects the current relationship of OSMA with various organizations and professional groups. In the event the House of Delegates would suggest specific projects for the Council or alter the current approach taken to the stated problems, recommendations should be included in the report of the Reference Committee.

Report of the COUNCIL ON PUBLIC HEALTH (APPROVED)

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Alcoholism and Drug Abuse Committee

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Emergency Medical Services Committee

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SECTION I THE COUNCIL

While it can be stated that the Council on Public Health was not "active" during the past

year, it must be realized that almost all activities of the Oklahoma State Medical Association are involved directly in the public health, since that is the function of the practice of medicine. The majority of this Council's functions are carried out through specialized committees. During the past year these committees have worked on a number of different projects.

SECTION II COMMITTEE ON ALCOHOLISM AND DRUG ABUSE

This committee's "Drug Abuse Treatment Manual" continues to be one of the most popular publications of the OSMA. Originally published four years ago, it was republished last year at the direction of the House of Delegates and was up-dated to include new information on drug abuse diagnosis and treatment, and a list of the drug treatment and counseling agencies available throughout the state.

Notice that the updated manual was given throughout the state and to all members of the Association. Subsequently, the OSMA has again exhausted its supply of this publication.

The committee has continued to promote the use of the 30 minute film entitled "What Did You Take?". This film was prepared in cooperation with the New York Medical Society and is designed to instruct physicians and other emergency care personnel in the emergency treatment of overdoses of heroin, barbituates, amphetamines and LSD.

The film has proved to be popular with allied health personnel, especially nurses and technicians working in emergency rooms. During the past year it has been used an average of 4 to 6 times each month. Primarily it is being shown at hospital staff meetings. However, on a few occasions it has been shown to general lay audiences. While the film is not really suitable for showing to the general public, its impact cannot be denied.

The emphasis of this committee has shifted during the past year. In years previous, most of its activities had been related to drug abuse, but in the past year they have been related to alcoholism. The Oklahoma State Medical Association lent its name to a statewide conference on alcohol abuse and alcoholism, held in the Center for Continuing Education in Norman March 5-7 of this year.

The OSMA participated not only by lending its name and promotional ability to the meeting, it also participated in the design of the program itself.

The committee also serves as a clearing house for information on changes in The Controlled Dangerous Substances Act that will be of interest to physicians.

A recurring problem has been called to the attention of the committee. This is a problem of pharmacists being put in the position of having to fill-in incompletely prepared prescriptions written for controlled substances. The Controlled Substances Act of 1970 holds the prescribing practitioner responsible if the prescription does not conform in all essential respects to the regulations. Although the primary responsibility rests with the prescribing practitioner, the pharmacist who receives an incompletely prepared prescription is not specifically prohibited by the regulations from completing the prescription prior to filling it.

The regular completion of prescriptions, however, must be discouraged. The physician who makes a regular habit of issuing incomplete prescriptions is reminded of the prescription requirements as set forth in the federal regulations. In no case should a pharmacist accept a prescription for filling that does not bear the patient's name, the name of the drug prescribed or the prescriber's signature.

According to the Drug Enforcement Administration of the Department of Justice, "it should not be necessary (for the pharmacist) to complete the prescription information on more than an occasional basis."

SECTION III COMMITTEE ON IMMUNIZATION

The primary purpose of this committee is to advise the Department of Public Health on questions of immunization and to assist them in publicizing immunization campaigns and schedules. During the past year, your committee has been active in both of these functions.

In August of 1974, the Oklahoma State Department of Health, Immunization Program, proceeded to update its immunization schedule for the state. The recommendation had been made that the poliomyelitis primary immunization section of the schedule for active immunizations be changed.

The American Academy of Pediatricians had recommended that poliomyelitis primary im-

munization . . . the primary series of three be completed by the first year. The Oklahoma Schedule had recommended three oral doses . . . two doses eight weeks or more apart, and a *third 8-12 months or more after the second*. The *underlined* portion was the problem. Health Departments across the country had noted an extreme drop in the number of children receiving this third dose. A survey taken in Oklahoma revealed that many first graders had never received the third oral dose.

Your committee voted to support the following change in the Oklahoma schedule for active immunization:

"Poliomyelitis — Primary immunization

"1. Infants — 8 weeks through 18 months: It is strongly recommended that the primary series of three doses of trivalent OPV be initiated during the first six months of life and completed by the first year. The basic series of three oral doses of TOPV should be administered at 2, 4 and 6 months or at 8-week intervals. A fourth dose of trivalent vaccine should be given to all children at approximately 18 months of age.

"2. Children and adolescents through 18 years: It is strongly recommended that the primary series of two doses of trivalent OPV be administered at 8-week intervals, followed by a third dose 6-months to one year later."

The above change has now been made in the Oklahoma Schedule. It also tends to couple the poliomyelitis doses with the DPT injections. Persons giving the immunizations can simply be instructed to give the poliomyelitis dose at the same time they give DPT.

This change has also made it easier for the Health Department and the Department of Education to enforce Oklahoma's law requiring certain immunizations for first-time school entry. Technically a child that has not received the three trivalent doses is not in compliance with the law. However, it should be noted that due to the many exclusions and some ambiguity, the law is not "strictly" enforced.

During the past year, your Association also participated in "Immunization Action Month." This was a major promotional campaign scheduled for October of 1974. IAM, as it was known, was directed on a national level by the Center for Disease Control and in Oklahoma by the Oklahoma State Department of Health Immunization Program.

Your Association participated by issuing news releases on IAM on its own letterhead

and distributing them to all newspapers, radio and television stations in the state.

SECTION IV MATERNAL MORTALITY COMMITTEE

Your committee has been very active during the past year. Among other things, it has considered the publication of a "Maternal Health Desk Book" for distribution to all hospitals and, upon request, to physicians practicing obstetrics.

The publication of the book was authorized by the House of Delegates at its 1974 meeting. The book outlines procedures to be followed whenever a physician is faced with an obstetrical emergency. The entire Maternal Mortality Committee has undertaken a review of material published in other states in order to make any Oklahoma publication as complete as possible.

For a number of years, your committee has been concerned that the data it is collecting is not being properly utilized. It has sought for ways to publish case reports in the OSMA Medical Journal that would not endanger the doctor-patient relationship. The committee is now in the process of establishing an exchange program with Maternal Mortality Committees in other states so that representative cases may be printed in Oklahoma and vice versa. By not revealing the state of origin of the case, and requiring that the other state do the same, the anonymity of all persons involved will be protected. At the same time, Oklahoma physicians will gain the benefit of knowing what has happened in maternal mortality situations.

The Maternal Mortality Committee of the OSMA and Oklahoma State Health Department has always worked on a voluntary basis. However, on occasion in the past the committee has been unable to receive the cooperation of the physician involved in a maternal mortality. The necessary records and data regarding the mortality were not made available to the committee.

The committee is very cognizant of the fact that its purpose is scientific and not punitive, in nature. However, the committee cannot ethically or morally turn away when it begins to suspicion that something untoward is happening. In order to assure itself that all necessary information could be made available, your committee queried the Oklahoma State Department of Health as to whether or

not the Commissioner of Health could grant subpoena powers to the committee. A memorandum regarding Oklahoma law on the subject was prepared by an OSMA staff person and forwarded to the legal section of the Health Department. Legal counsel for the Health Department concurred and on March 6 of this year, 1975, R. LeRoy Carpenter, MD, Commissioner of Health for the state of Oklahoma issued a letter of authorization to the OSMA Maternal Mortality Committee. The letter is as follows:

"This letter is to designate the Maternal Mortality Committee as an official representative of the State Department of Health, to carry out the duties pursuant to Title 63, Section 1-106, Sub-Sections (b) (1) and (5), to make investigations, inquiries and studies concerning the causes of disease and causes of mortality in infants in the State of Oklahoma. The Committee is further delegated the authority as authorized to me (The Commissioner) under Title 63, Section 1-106, Sub-section (7) to 'issue subpoenas for the attendance of witnesses and the production of books and records at any hearing to be conducted by The Commissioner or the State Board of Health.' "

Your Committee pledges that it will use this subpoena power with much discretion and only after all other avenues to obtain the necessary information have been exhausted.

During the past year, a report was compiled by the Maternal-Child Health Services Section of the State Health Department on the deaths studied by the Maternal Mortality Committee from 1969 until 1972. A total of 51 deaths were studied during that period of time. It was determined that five of the deaths were due to non-obstetrical causes, 14 to hemorrhages, 3 to toxemia, 13 to sepsis and infection, 7 to embolisms and 9 to other causes, such as sickle cell crisis, heart disease, cardiac arrest brought on by hyperthyroidism, and acute cardiopulmonary collapse.

One difficulty that the committee has encountered in the past was simply knowing whether or not a death was pregnancy related. The State Health Department Statistical Division has been asked to include a question on death certificates so that the attending physician at death can indicate whether or not the deceased had been pregnant within 90 days prior to death. This addition to the death certificate will enable the committee to detect

maternal mortalities that in the past have been masked by time.

One interesting statistic revealed by the work done by the Maternal-Child Health Service was the fact that deliveries by mid-wives or non-professional persons have slowly been increasing. From 2.5 per 1,000 births in 1970, such deliveries reached 3.3 per 1,000 in 1973. Although the rate is increasing slightly, it is still less than half the rate of only 10 years ago in 1965. In that year, 7.1 per 1,000 deliveries was by a mid-wife or other person.

SECTION V. COMMITTEE ON LABORATORY QUALITY

Your committee on Laboratory Quality continues to promote proficiency testing for physician office laboratories. Oklahoma, as one of the first states in the nation to endorse and promote such a program, has a long history of effective participation in the College of American Pathologists-Proficiency Evaluation Program. The 1975 PEP series allows 124 opportunities to evaluate the skills and compare performance of the physician's office laboratory. Changed from 1974, the 1975 program provided specimens 8 times a year rather than quarterly as done in the past. Data accumulated in the PEP study is for the exclusive use of the participants. However, statistics obtained are published and anonymous copies of the individual laboratory results are provided the Committee for monitoring. The evaluation report gives the Committee the opportunity for individual or group analysis and permits the isolation of an individual or group problems if they exist. Fortunately, the physicians participating in PEP have improved the quality of their laboratory work to the point that all are providing quality laboratory services.

In 1974 there were 55 physician office laboratories participating in the PEP Program. In 1975 there are only 25. Part of this decrease is due to the fact that additional testing programs are available, the newest is a program developed by the American Society of Internal Medicine. The decrease is significant enough that the Committee feels a survey should be conducted among those physicians that are most likely to perform laboratory work within their offices to see if there is a reason for the non-participation.

The Committee feels that a great deal of the information that is accumulated as a result of

the laboratory testing program could be used in educational programs for physicians and medical technicians. It is planned that after the 1975 Series is complete an analysis of the entire year's results will be undertaken for the purpose of writing papers to be presented at various medical and medical technologists' meetings.

Physicians should be aware there is growing concern among governmental units about the quality of services performed in physician office laboratories. Both California and Maryland require proficiency testing for physician office laboratories and other states have considered similar legislation. We feel that voluntary participation in testing programs will produce a higher quality of laboratory medicine than would mandatory control. Because of the record of participation by Oklahoma physicians and the historical data available, we feel we are justified in resisting efforts for a required testing program.

RECOMMENDATIONS:

1. That the activities of the Committee be continued;
2. That the Committee be permitted to run a survey among physicians that are most likely to have office laboratories to ascertain their attitude about the proficiency testing and the necessity for continued monitoring;
3. That the House of Delegates endorse the concept of joint continuing education programs between physicians and medical technicians.

*SECTION VI
COMMITTEE ON
EMERGENCY MEDICAL SERVICES*

During the waning days of the 34th Oklahoma Legislature, lawmakers passed Senate Joint Resolution 31 which set forth a state question authorizing the creation of emergency medical service boards and districts. If approved the district was authorized to vote up to an 8 mill tax levy to purchase and maintain emergency medical services. OSMA's Legislative Committee supported passage of the resolution.

State Question 504, as the issue became known, had strong support from some segments of the Oklahoma community, primarily those communities which were without ambulance and emergency care facilities, or had a

limited program of such resources. Others opposed the issue on the grounds the recurring tax levy was exorbitant, that the language of the resolution was ambiguous and the EMS Board structure was not equitable.

Your committee researched the issue carefully. We visited with Chamber of Commerce representatives from the metropolitan cities, we received input from the State Chamber, Department of Health and Oklahoma Municipal League. It was the Committee's opinion after hearing all the evidence, that State Question 504 deserved the support of Oklahoma physicians.

In early September the Chairman contacted all newspaper editors in the state and indicated the Association's approval of the question. Simultaneously, letters and fact sheets went to all County Society Presidents and Secretaries.

The issue received considerable editorial support, including that of large Metropolitan dailies. However, State Question 504 was defeated by a vote of 208,861 to 314,967.

It is interesting to study the support the Question received. Even with organized opposition, over 200,000 voters indicated that EMS services in Oklahoma were inadequate, a fact well known to the Committee, statistically verifiable but unacceptable politically.

There are indications that Emergency Medical Services will receive higher priority rankings in the future than in the past. A portion of Governor Boren's address to the Joint Legislature emphasized the financing of quality emergency medical services. ". . . I will also direct that emergency medical services be improved in all geographical parts of the State. I will use available federal highway safety funds under the control of the Governor's office to support the training of ambulance crews and to obtain radios and monitoring equipment for emergency vehicles. Regardless of where they live, all Oklahomans should be within minutes of adequate health care . . ."

Representatives of the Governor's office, State Health Department and OSMA have collaborated on legislation that will help implement the Governor's plan. Senate Bill 312 which will vest regulatory authority over emergency medical services in the State Board of Health has been introduced. The bill also creates an Emergency Medical Services Advisory Council to assist in carrying out the provisions of the Act. If passed, the Council will make recommendations to the State Board

of Health, for its approval or disapproval, regarding all facets of emergency medical services, including but not limited to:

1. Qualifications for Certification of ambulance personnel;
2. Patient care equipment for ambulances; and
3. Communications equipment, local and statewide.

Heretofore, these services have not been regulated or coordinated by a state agency.

The Oklahoma Trauma Research Society should receive a vote of confidence from the House of Delegates. OTRS, with limited manpower and funding, but with great support from volunteer physicians has trained over 1,400 Emergency Medical Technicians (ambulance), 800 or more have qualified for national registry. More important than the number is the fact that the technicians were trained in 56 different communities, almost entirely outside large metropolitan areas, thereby insuring a better distribution of qualified help. The Committee maintains close liaison with OTRS and anticipates continued support of their training program.

The State Department of Health has organized a special EMS division and has recently completed and submitted to the Department of Transportation, a comprehensive Statewide Emergency Medical Service System Plan. The plan did receive favorable consideration but for several reasons did not get funded. One overriding issue is the lack of state regulations over EMS services. It is estimated that 70% of Oklahoma's ambulance services operate with substandard vehicles, without adequate personnel training, and lacking the necessary equipment for life-saving procedures. These conditions result in the estimate that one of every four accident or sudden illness victims dies unnecessarily.

Faced with these problems, the Commissioner of Health activated his Emergency Medical Services Advisory Council in July of 1974. EMSAC created by law in the 34th Oklahoma Legislature has five OSMA members, most of whom serve on this committee. Subcommittees were formed and it was from one of these (Sub-Committee on Legislation) that came SB 312.

The Committee would like to express its appreciation to the many physicians who are participating in EMS activities. We mentioned

earlier the training program sponsored by OTRS in 56 separate communities. In every case, a local physician was involved as a coordinator and in most cases as an instructor. Oklahoma County physicians have organized CORP—Central Oklahoma Rescue Patrol—for the purpose of improving the Emergency Medical System in Oklahoma City. CORP, which was recently incorporated, will launch an area-wide education program on cardiopulmonary resuscitation.

Public Law 92-641 — The National Health Planning and Resources Development Act of 1974 (See Board of Trustees Report) could have a major impact on emergency medical services. Plans now under scrutiny by Governor Boren could result in multiple health planning districts in Oklahoma. Each district will have almost autonomous control over the planning and implementation of health programs, including EMS systems. It is important that if the multiple district option is chosen, that physicians at the local level influence health planning to insure statewide coordination.

SUMMARY

Reviewing past activities, current programs and future plans, it appears that Emergency Medical Services in Oklahoma are destined for improvement. The vote on State Question 504 indicates there is a broad segment of the populace concerned about the availability of emergency services; efforts by Governor Boren, the Legislature and the State Health Department could result in some supervisory authority and better funding; support communities have given the OTRS program and the great interest shown by physicians all lead to the conclusion that finally, proper emphasis is being placed on Emergency Medical Services.

RECOMMENDATIONS:

1. The House of Delegates approve the concept of a statewide coordinated Emergency Medical Services System;

2. The House of Delegates encourage OSMA members to participate in the planning and implementation of programs to improve Emergency Medical Services.

Report of the
**COUNCIL ON SOCIO-ECONOMIC
ACTIVITIES**
(APPROVED)

Council Members

Roger J. Reid, MD, Ardmore, Chairman
Charles Bodine, MD, Oklahoma City

Thurman Shuller, MD, McAlester
 Roger Haglund, MD, Tulsa
 Ed L. Calhoon, MD, Beaver
 Robert Sukman, MD, Oklahoma City
 Arthur E. Schmidt, MD, Oklahoma City
 Ann K. Kent, MD, Muskogee
 Walter E. Brown, MD, Tulsa
 Howard B. Keith, MD, Shattuck
 Robert R. Dugan, MD, Oklahoma City
 Harold Stout, MD, Waurika

Peer Review Committee A

Edward L. Moore, MD, Tulsa, Chairman
 Tony Puckett, MD, Oklahoma City
 Robert M. Shepard, Jr., MD, Tulsa
 Samuel A. Wheeler, MD, Oklahoma City
 Richard G. Dotter, MD, Oklahoma City
 John A. McIntyre, MD, Enid
 Leonard H. Brown, MD, Tulsa
 Worth M. Gross, MD, Tulsa
 Joseph Messenbaugh, MD, Oklahoma City
 Jack L. Richardson, MD, Tulsa
 Frank L. Adelman, MD, Enid
 Bobby Gene Smith, MD, Oklahoma City
 Samuel C. Jack, MD, Lawton
 Roger Haglund, MD, Tulsa
 William R. McShane, MD, Tulsa
 Charles R. Gibson, MD, Chickasha

Peer Review Committee B

Edward L. Moore, MD, Tulsa, Chairman
 Arthur E. Schmidt, MD, Tulsa
 William E. Hood, MD, Oklahoma City
 David D. Rose, MD, Ardmore
 Alfred H. Bungardt, MD, Tulsa
 Bill G. Henley, MD, Lawton
 Richard M. Taliaferro, MD, Ada
 David B. Brinker, MD, Oklahoma City
 Michael Berkey, MD, Tulsa
 Joseph Salamy, MD, Tulsa
 Neil B. Kimerer, MD, Oklahoma City
 Leon Combs, MD, Shawnee
 Thomas Henley, MD, Oklahoma City
 S. Fulton Tompkins, MD, Oklahoma City
 William J. Forrest, MD, Oklahoma City
 Schales Atkinson, MD, Oklahoma City
 Victor L. Robards, Jr., MD, Tulsa

Peer Review Consultants

Robert Morgan, MD, Oklahoma City
 Kent Braden, MD, Oklahoma City
 Robert L. Imler, Jr., MD, Tulsa
 William B. Renfrow, MD, Oklahoma City
 L. Chester McHenry, MD, Oklahoma City
 Lyle W. Burroughs, MD, Oklahoma City

Charles J. Wine, MD, Oklahoma City
 A. Manson Fuller, MD, Tulsa
 Gerald W. Boles, MD, Oklahoma City
 Thomas L. Ashcraft, MD, Tulsa

SECTION I THE COUNCIL

The Council has been assisted throughout the year by able committees operating under its jurisdiction, and the Council *per se* has had no matters referred to it which required its direct involvement.

Peer Review Committee

In 1966, following the enactment of Medicare, the OSMA established a Peer Review or Insurance Review Committee. The purpose of the committee throughout the years has been to adjudicate claims involving health programs which reimburse physicians according to "usual, customary and reasonable" fee.

Over the years, the structure and the organization of the committee has changed. In 1966 it started as a single committee that met on call of the Chairman. As the number of cases began to increase, it was necessary for the committee to meet monthly. Because of an increased case load, two years ago it became necessary to split the committee into two sub-committees, each with its own chairman, to meet on alternate months. In addition, a consultation or consultant sub-committee was established to assist either of the two sub-committees whenever a claim came up involving one of the specialties or sub-specialties not represented on the main committee.

The committee's name was changed three years ago from "Medical Insurance Review" to "Peer Review" by the House of Delegates. Its purpose, however, remained the same. As stated in the Peer Review function adopted by the House, the Committee ". . . shall serve the function of seeking the objective reconciliation of unusual medical insurance claims involving members of the OSMA and health insurance coverages which offer payment of customary and reasonable fees."

During the last year, the committee adopted a new "OSMA Peer Review Summary" form so that it might streamline its operation. The rules of the committee require that each person filing a case for hearing must fill out the summary form as completely as possible.

It should be understood that the term "case"

as used in this report does not necessarily mean that the committee considered only a single claim, or a single charge. In many cases, numerous claims were involved. Although the total amount of money in controversy in any one case might not be much, the case could establish a precedent for the insurance company or carrier to follow in the future. As an example, if the committee recommends that the carrier recognize a higher fee for a given procedure, that recommendation will affect not only the outcome of the case in question, but all other charges received for the same procedure by that carrier.

From June 1, 1974 to March 31, 1975, the 30 members of the two Peer Review Subcommittees had reviewed 169 cases, some involving multiple charges and/or multiple patients.

Of the 169 cases considered, 84 involved Oklahoma Blue Shield. Medicare accounted for 19 cases, the Department of Institutions, Social and Rehabilitative Services had 28 cases, and private insurance companies accounted for 37.

Resolution No. 1
(DISAPPROVED)

INTRODUCED BY: Oklahoma County Medical Society

SUBJECT: Insurance Claim Forms

REFERRED TO: Reference Committee No. I

WHEREAS, almost every insurance company has a different and unique insurance claim form, but requiring almost essentially the same information in all instances; and

WHEREAS, the physicians of Oklahoma are asked to fill out all the different types of forms, requiring extensive time and expense; therefore be it

RESOLVED, that the physicians of Oklahoma be encouraged to use the American Medical Association's Uniform Claim Form for all accident and health insurance reports; and be it further

RESOLVED, that if an individual insurance company requires its own claim form to be filled out, an appropriate charge be made to the insurance company as reimbursement to the physician for his time and inconvenience.

Resolution No. 2
(DISAPPROVED)

INTRODUCED BY: Carter, Love Marshall Counties Medical Society

SUBJECT: Proposed Amendments to the By-Laws of the Oklahoma State Medical Association.

REFERRED TO: Reference Committee No. I

It is proposed that Chapter I, Section 1.00 of the Oklahoma State Medical Society By-Laws be amended as follows: The last sentence in the paragraph which now reads "All members of component societies and of this association are required to belong to the American Medical Association" shall be amended to read as follows: "Members of the Oklahoma State Medical Society and component county societies are not required to belong to the American Medical Association, but each member may at his option elect to assume membership in the American Medical Association."

It is also proposed that Chapter II, Section 2.00 shall be amended to read as follows: "American Medical Association Dues. Members of the Oklahoma State Medical Society are not required to belong to the American Medical Association. For those members who voluntarily elect to assume membership in the American Medical Association, those dues and assessments shall be collected and remitted in the manner provided by the by-laws of the American Medical Association."

It is also proposed that Chapter V, Section 7.036 of the Oklahoma State By-Laws be amended as follows: "Appeals to the American Medical Association. Judicial decisions of the Board of Trustees which affect members of the American Medical Association may be appealed to the Judicial Council of the American Medical Association in accordance with that organization's constitution and by-laws. In such event the decision of the Board of Trustees shall not be suspended pending the appeal to the American Medical Association Judicial Council. Members of the Oklahoma State Medical Association who elect not to become members of the American Medical Association, may not appeal adverse judicial decisions to the American Medical Association."

Resolution No. 3
(DISAPPROVED)

INTRODUCED BY: Tulsa County Medical Society

SUBJECT: Repeal of the Provisions in the By-Laws of Oklahoma State Medical As-

sociation Requiring Membership in American Medical Association.

REFERRED TO: Reference Committee No. I

WHEREAS, Oklahoma State Medical Association is one of only seven state medical associations requiring its members to be members of American Medical Association; and

WHEREAS, Referendums conducted by Oklahoma State Medical Association in recent years indicate a growing and substantial number of its members object to the compulsory aspects of AMA membership; therefore be it

RESOLVED, that the OSMA House of Delegates, acting at the annual meeting of April 23-26, 1975, approve appropriate amendments to the By-Laws of Oklahoma State Medical Association to delete the requirement that its members be members of American Medical Association; and be it further

RESOLVED, that the Oklahoma State Medical Association urge its members to voluntarily be members of American Medical Association.

Recommended Amendments to Complete the Objectives of Resolution No. 3

It is proposed that Chapter I, Section 1.00 of the By-Laws be amended as follows:

The last sentence in the paragraph, which now reads "All members of component societies and of this association are required to belong to American Medical Association," shall be amended to read as follows: "Members of this association are not required to belong to American Medical Association, but each member at his option may elect to assume membership in American Medical Association."

It is further proposed that Chapter II, Section 2.00 shall be amended to read as follows:

"Section 2.00. AMERICAN MEDICAL ASSOCIATION DUES. Members of this association are not required to belong to American Medical Association. For those members who voluntarily elect to assume membership in American Medical Association, AMA dues and assessments shall be collected and remitted in the manner provided by the By-Laws of the American Medical Association."

It is further proposed that Chapter V, Section 7.036 of the By-Laws shall be amended to read as follows:

"7.036. APPEALS TO AMERICAN MEDICAL ASSOCIATION. Judicial decisions of the Board of Trustees which affect members of the

American Medical Association may be appealed to the Judicial Council of the American Medical Association in accordance with that organization's Constitution & By-Laws. In such event the decision of the Board of Trustees shall not be suspended pending the appeal to the AMA Judicial Council. Members of the Oklahoma State Medical Association who elect not to become members of the American Medical Association, may not appeal adverse decisions to the American Medical Association."

*Resolution No. 4
(APPROVED)*

INTRODUCED BY: Tulsa County Medical Society

SUBJECT: Support of Emergency Medical Services Systems.

REFERRED TO: Reference Committee No. III

WHEREAS, the Emergency Medical Services System is a vital component of the health care delivery system; and

WHEREAS, both professionals and lay persons recognize the inadequacies in many areas of the present Emergency Medical Services System; and

WHEREAS, the physician plays a vital role in the design and implementation of Emergency Medical Services Systems; and

WHEREAS, the Oklahoma State Medical Association recognizes the desirability of physician participation in the training of Emergency Medical Technicians and other allied health personnel for improving the delivery of Emergency Medical Services; therefore be it

RESOLVED, that the Oklahoma State Medical Association support the concept of a comprehensive system of Emergency Medical Services, and that physicians evidence their support by participation in activities of design and development of Emergency Medical Services Systems; and be it further

RESOLVED, that physicians support and participate in the training of Emergency Medical Technicians and other allied health personnel in the delivery of such services; and be it further

RESOLVED, that physicians participate in the assurance of the capability of hospitals to deliver quality emergency care; and be it further

RESOLVED, that Oklahoma State Medical Association urge other health professional or-

ganizations to resolve their support of such Emergency Medical Services Systems.

Resolution No. 5
(DISAPPROVED FOR
SUBSTITUTE RESOLUTION)

INTRODUCED BY: Kingfisher County Medical Society

SUBJECT: Small Hospital PSRO Problems

REFERRED TO: Reference Committee No. III

WHEREAS, the new utilization review regulations pertaining to Medicare and Medicaid has placed an unacceptable manpower problem on the small hospitals of the State of Oklahoma; and

WHEREAS, the continued operation of this pernicious law will lead to the closure and financial crippling of many small Oklahoma hospitals; therefore be it

RESOLVED, that the Oklahoma State Medical Association recommends that PSRO exception be granted to hospitals with ten or fewer active medical staff members, and that the Oklahoma Congressional Delegation be petitioned by OSMA to introduce legislation effecting this exception.

Resolution No. 6
(DISAPPROVED)

INTRODUCED BY: Kingfisher County Medical Society

SUBJECT: Voluntary Association Membership

REFERRED TO: Reference Committee No. I

WHEREAS, the officers of many organizations tend to ignore a captive audience; and

WHEREAS, the American Medical Association has exhibited a considerable indifference to the desires and ideals of the average U.S. physician; and

WHEREAS, the American Medical Association has failed to exhibit expected financial prudence; therefore be it

RESOLVED, that the Oklahoma State Medical Association change its constitution to permit membership in the State and County Societies without mandatory membership in the American Medical Association, effective January 1, 1975.

Resolution No. 7
(REFERRED TO THE

COUNCIL ON INSURANCE)

INTRODUCED BY: Kingfisher County Medical Society

SUBJECT: Release of Information to Third Party Carriers

REFERRED TO: Reference Committee No. II

WHEREAS, with continued encroachment of third party carriers into confidential medical records justifying according to their needs either insurability of a patient or if a claim is properly covered by them; and

WHEREAS, the third party uses a blanket release of information signature of the patient they acquired upon issuing said policy which may be months to years previous; and

WHEREAS, information obtained from the doctors' clinical notes may be differential diagnosis only and not a proven diagnosis requiring further diagnostic procedure; and

WHEREAS, this information labeled "pre-existing illness" may be used without further proof of diagnosis from other physicians and also not allowing further recourse by the patient; and

WHEREAS, most reputable insurance companies already require complete physical examination by physicians before life or health insurance is obtained; therefore be it

RESOLVED, the Oklahoma State Medical Association is opposed to medical record "snooping" by third party carriers, unless such information is asked by the physician giving said applicant the insurance physical so as to complete his insurance report concerning insurability and that the Oklahoma State Medical Association is strongly opposed to medical record "snooping" after a claim has been filed to try to prove pre-existing illness.

Resolution No. 8
(REFERRED TO THE
COUNCIL ON INSURANCE)

INTRODUCED BY: Kingfisher County Medical Society

SUBJECT: Pre-existing Illnesses

REFERRED TO: Reference Committee No. II

WHEREAS, it is frequently the case that the patient purchases health or life insurance and maintains this insurance in force, through payments for many years; and

WHEREAS, it frequently occurs that patients find out after the fact or after the illness that the insurance will not pay because of a "pre-existing condition"; and

WHEREAS, the patient has, over a long period of time, made payments in good faith with the expectation that the illness, injury or et cetera will be covered, only to find out after the fact that this particular problem is excluded under the "pre-existing illness"; therefore be it

RESOLVED, that the insurance committee of the Oklahoma State Medical Association be instructed to see that legislation is introduced and vigorously worked for the passage of legislation, requiring all insurance companies operating within the State of Oklahoma, to notify their clients either prior to the issuance of a policy or very shortly thereafter in very clear and concise terms, the exact extent of coverage and conditions and/or situations under which the insurance will not be applicable.

Resolution No. 9
(APPROVED)

INTRODUCED BY: Kingfisher County Medical Society

SUBJECT: Repeal of HEW's Professional Standards Review Organization

REFERRED TO: Reference Committee No. III
WHEREAS, PSRO violates the confidentiality between the patient and physician; and

WHEREAS, PSRO increases the expense of hospital care to the patient who has to absorb the administrative cost for carrying out the reviews as stipulated by the legislation; and

WHEREAS, the present PSRO legislation opens up avenues for other regulatory controls such as the utilization review changes made for Medicare and Medicaid patients; and

WHEREAS, PSRO establishes guidelines based on statistical data rather than on actual patient outcome; therefore be it

RESOLVED that HEW's Professional Standards Review Organization law be repealed and that this stand for repeal be adopted by the Oklahoma State Medical Association.

Resolution No. 10
(DISAPPROVED FOR
SUBSTITUTE RESOLUTION)

INTRODUCED BY: Kingfisher County Medical Society

SUBJECT: Non-compliance with Utilization Review Regulations

REFERRED TO: Reference Committee No. III

WHEREAS, the Federal regulations on Utilization Review of Medicare and Medicaid cases have become progressively more repressive; and

WHEREAS, the last edition of these regulations, proclaimed in November of 1974 to become effective February 1, 1975, actually will cause a deterioration of medical care, compromise the confidentiality of the patient, and impose a nonproductive paperwork task on the overworked physician; and

WHEREAS, the American Medical Association is now suing the government on the constitutionality of these pernicious regulations; therefore be it

RESOLVED, that the Oklahoma State Medical Association recommend that those of its membership on hospital staffs not comply with these regulations, and that the Congressional delegation be notified of this recommendation.

Resolution No. 11
(DISAPPROVED)

INTRODUCED BY: Comanche-Cotton-Tillman County Medical Society

SUBJECT: Collective Bargaining By the AMA
REFERRED TO: Reference Committee No. III

WHEREAS, the American Medical Association has failed to adequately represent the majority of its members in the recent past with its present leadership and as it is currently organized; therefore be it

RESOLVED, that the next national meeting of the AMA devote as much time as is necessary to either change the constitutional structure of the AMA or to add a division of the AMA to allow its members to be represented by an effective collective bargaining agent to deal with all organizations involved in health care; and be it further

RESOLVED, that this action has not been taken by choice, but has been forced upon the medical profession by recent and current actions of the political leadership of the United States.

Resolution No. 12
(APPROVED AS
EDITORIALLY AMENDED)

INTRODUCED BY: Oklahoma County Medical Society

SUBJECT: AMA Publications

REFERRED TO: Reference Committee No. I

WHEREAS, the American Medical Association has found itself in a financially embarrassing position and, therefore, has found it necessary to assess AMA members \$60, which assessment has resulted in the loss of many AMA members over the country; and

WHEREAS, the AMA publishes numerous specialty journals, magazines, and other incidental publications, that have resulted in a loss of nearly \$5.5 million per year when these were distributed free of charge or at a nominal subscription rate to its members; and

WHEREAS, it has been learned from interviews throughout the country that most of these publications are not being utilized by AMA members, therefore be it

RESOLVED, that the Oklahoma State Medical Association urge the American Medical Association to discontinue, immediately, free distribution of all publications, except for JAMA; and be it further

RESOLVED, that the AMA establish a subscription price that will pay for its other publications, or, if such a subscription price is not feasible, that it discontinue, immediately, the publication of specialty journals, Prism, and all other magazines, leaflets, and brochures not fiscally sound.

Resolution No. 13
(DISAPPROVED FOR
SUBSTITUTE RESOLUTION)

INTRODUCED BY: Oklahoma County Medical Society

SUBJECT: Non-participation in Utilization Review Regulations

REFERRED TO: Reference Committee No. III

WHEREAS, the published regulations appearing in the Federal Register November 29, 1974, implementing utilization review are inconsistent with good patient care, infringe on the doctor/patient relationship, threaten the confidentiality of that relationship, promulgate the deterioration of quality medical care, pose the potential threat of closing many hospitals and threaten our patients with possible loss of hospital privileges and financial assistance, therefore be it

RESOLVED, that the physicians of the state of Oklahoma elect a position of non-participation in the utilization review regulations.

INTRODUCED BY: Kingfisher County Medical Society

SUBJECT: Non-participation in Utilization Review

REFERRED TO: Reference Committee No. III

WHEREAS, the published regulations appearing in the Federal Register on November 29, 1974, implementing Utilization Review are inconsistent with good patient care, infringe on the doctor-patient relationship, constitute unsolicited and therefore unethical consultation, threaten the confidentiality of that relationship, promulgate the deterioration of quality medical care, pose the potential threat of closing many hospitals and threaten our patients with possible loss of hospital privileges and financial assistance; and

WHEREAS, Peer Review and Utilization Review have been traditionally performed by the profession to assure quality medical care, not cost control, and is best handled at the local level so that it can take into consideration local problems; and

WHEREAS, any nationwide method of Utilization Review must necessarily ignore such local problems and cannot be accurately varied into size of hospital facility or medical staff; and

WHEREAS, any such national scheme will result only in a rationing of health care services to patients; therefore be it

RESOLVED, that the physicians of the State of Oklahoma vigorously support the American Medical Association's lawsuit against these onerous regulations, and, therefore be it

RESOLVED, that the physicians of the State of Oklahoma will continue Utilization Review and Peer Review on an individual hospital basis, and will not participate in Utilization Review as outlined in the above cited regulations, and

WHEREAS, the Oklahoma State Medical Association recognizes that this stance will require a public relations campaign to inform the general public as to the necessity for this position, now therefore be it

RESOLVED, that the House of Delegates of the Oklahoma State Medical Association authorize the OSMA Board of Trustees to institute a voluntary assessment to establish an adequate public relations campaign budget in the event that the Federal Court upholds the

regulations as currently published, and therefore be it further

RESOLVED, that the Oklahoma State Medical Association seek the broadest possible base of support in such a campaign by inviting another cooperative physician by other state medical associations throughout the United States.

(Late Resolution)

INTRODUCED BY: William Garnier, MD, and Sidney Williams, MD

SUBJECT: Eyeglass Prescriptions from Ophthalmologists

REFERRED TO: Reference Committee No. III

WHEREAS, Section 7, Number 490 of the Opinions and Reports of the Judicial Council of the American Medical Association (1966) entitled "Right of Patient to Copy of Prescription", states: "A patient is entitled to a copy of his or her prescription for glasses, drugs, or appliances and he has the privilege of having the prescription filled wherever he wishes, (Judicial Council 1963)"; and

WHEREAS, the peculiarities of Oklahoma State Law place an extraordinary burden upon the ophthalmologists who issue such a prescription by holding him responsible (in Title 59, Section 942 of the Oklahoma Statutes) for the "full effect" of any eyeglasses furnished in response to that prescription, no matter who furnishes them; and

WHEREAS, this extraordinary responsibility imposes a liability upon the ophthalmologists unlike the liability imposed by prescriptions for medication; therefore be it

RESOLVED, that the Oklahoma State Medical Association House of Delegates recognize that there is not an ethical admonition on the part of an ophthalmologist to release an eyeglass prescription to a patient unless he wishes to do so and is satisfied that it will be filled in a correct and non-harmful manner.

Resolution No. 14

(APPROVED AS AMENDED

AS SUBSTITUTE RESOLUTION)

INTRODUCED BY: William Garnier, MD, and Sidney Williams, MD

SUBJECT: Eyeglass Prescriptions from Ophthalmologists

REFERRED TO: Reference Committee No. III

WHEREAS, Section 7, Number 490 of the Opinions and Reports of the Judicial Council of

the American Medical Association (1966) entitled "Right of Patient to Copy of Prescription", states: "A patient is entitled to a copy of his or her prescription for glasses, drugs, or appliances and he has the privilege of having the prescription filled wherever he wishes, (Judicial Council 1963)"; and

WHEREAS, the peculiarities of Oklahoma State Law place an extraordinary burden upon the ophthalmologists who issue such a prescription by holding him responsible (in Title 59, Section 942 of the Oklahoma Statutes) for the "full effect" of any eyeglasses furnished in response to that prescription, no matter who furnishes them; and

WHEREAS, this extraordinary responsibility imposes a liability upon the ophthalmologists unlike the liability imposed by prescriptions for medication; therefore be it

RESOLVED, that the Report of the Judicial Council of the AMA be waived until such time that the OSMA statute is changed or waived.

Resolution No. 15

(APPROVED)

INTRODUCED BY: Medical Center Liaison

Committee and the Legislative Committee

SUBJECT: Study of OU College of Medicine's

Admission Policy

REFERRED TO: Reference Committee No. II

WHEREAS, at the present time there is concern that admission policies of the University of Oklahoma College of Medicine are not equitable for the entire State of Oklahoma; and

WHEREAS, the selection of students may have a beneficial effect on the distribution of physicians in the State, especially in the rural areas of Oklahoma, now experiencing an acute shortage of medical personnel; and

WHEREAS, in order to better serve all the people of Oklahoma with good medical care it appears that it is in the best interest of the State to have all geographic regions of the State proportionately represented on the Board of Admissions; and

WHEREAS, the Oklahoma Legislature has under consideration, a Senate Resolution that would mandate the composition of the College of Medicine's Board of Admissions; and

WHEREAS, the composition of the Board of Admissions of the Oklahoma University College of Medicine and the policies whereunder it operates has and is a major concern to practicing physicians of the State of Oklahoma;

NOW, THEREFORE, BE IT RESOLVED by the House of Delegates of the Oklahoma State Medical Association, duly assembled:

SECTION 1. (A) That the Chairman of the Board of Trustees of the Oklahoma State Medical Association, with the concurrence of the Presidents of County Medical Societies within each district, appoint forthwith, two physicians from each of Oklahoma's six Congressional Districts to serve on a special study committee.

(B.) That the Provost of the University of Oklahoma Health Sciences Center be requested to appoint five physicians representing the faculty and staff of the Oklahoma University College of Medicine to likewise serve on the Committee.

SECTION 2. That the above established Committee convene as often as necessary to study in depth, the admissions policies of the Oklahoma University College of Medicine and the effect said policies have on the distribution of physicians in Oklahoma;

SECTION 3. That a full report of the finding of the Committee be filed with the Executive Committee of the Oklahoma Legislative Council at least 30 days prior to the convening of the 2nd Session of the 35th Oklahoma Legislature.

SECTION 4. That duly authenticated copies of this Resolution, signed by the Speaker of the House of Delegates shall be transmitted forthwith, to the Governor of the State of Oklahoma, President Pro Tempore of the Oklahoma Senate, Speaker of the Oklahoma House of Representatives and the Provost of the Oklahoma University Health Sciences Center.

SECTION 5. That copies of this Resolution be transmitted to all members of the Oklahoma State Senate and the Oklahoma House of Representatives.

SECTION 6. That the findings of the report be published in *The Journal of the Oklahoma State Medical Association*.

SECTION 7. That the Medical Center Liaison Committee report the results of the Committee's findings to the House of Delegates at the next annual meeting.

(Late Resolution)
Resolution No. 16
(DISAPPROVED)

INTRODUCED BY: Kent Braden, MD
SUBJECT: Physician-Patient Relationship
REFERRED TO: Reference Committee No. III

WHEREAS, even though we, as physicians, face the eleventh hour, it is not too late for us to guide our own destiny.

We have seen our image decline, the incidence of malpractice claims rise, and ever increasing amounts of our time consumed by nonsensical clerical servitude and meaningless monotonous meetings. This demise and debacle began simultaneously with the first acceptance of a third party intermediary, thereby breaching the foundation of our profession — the doctor-patient relationship.

What may have initially been an unwitting endeavor progressed to a willing participation and then catapulted to a subservience, and almost extinction of the noblest of professions. The pot of porridge has long since run dry and we now face the reality of a hired employee who is unhappy with his job.

We have tried in vain to persuade, to educate and to reason with all third parties. We have striven to stem the tide of the decline of the greatest health care system the world has ever known. In our anguish we have overlooked a very simple truth. When an employee can no longer tolerate his job, he should resign. It is time we relinquished our job as providers for consumers and returned to our profession as physicians caring for patients.

We have too long been coerced into a position of interpreters and enforcers for third parties by our secretarial completion of forms, and thus invoked the wrath of both our patients and third parties.

We have too long labored under the daily dread and fear of malpractice claims.

As physicians, we are the first to admit, as humans, we have malperformers in our ranks. No other profession is as anxious to promote the continued quality and advancement of knowledge and care as we. We have long performed peer services and need to constantly seek to further improve our peer structure.

The time has now come to stand on the courage of our convictions — or sink into the mire of mediocrity. If we fail at this time to return to the principles that have so long sustained our profession; if we refuse to assert our rights — then let us henceforth be silent. He who will not stand to fight for what is right should not stand to speak.

BE IT THEREFORE RESOLVED, that

(1) The physicians of OSMA shall accept payment from no one — *NO ONE* — except their patients and/or their families.

(2) The physicians of OSMA shall render to

patients an itemized bill listing in detail all charges for tests, surgeries, etc. with dates and diagnosis and shall sign same, but will fill out no other forms of any description.

(3) The physicians of OSMA shall deal professionally directly only with their patients, thereby taking a stand of non-participation in utilization review, PSRO, National Health Insurance or any other ill-conceived plan devised by a third party which would appear to be detrimental to quality health care.

(4) The Board of Trustees shall perform or appoint a committee to perform, the planning of review boards to render judgment affecting the legitimacy of malpractice claims.

(5) The Board of Trustees shall perform or appoint a committee to perform, the structure of a simple, but effective, guideline for improving peer review.

(6) The Board of Trustees shall perform or appoint a committee to perform, a standardized pamphlet to be used by all physicians of OSMA explaining to patients our procedures and the reasons, and inviting them to inquire about and discuss any and all fees at their pleasure.

BE IT FURTHER RESOLVED, that copies of this Resolution be distributed to every member of the Oklahoma Medical Association and that it be published in the official publications of the Association. ☐

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The
JOURNAL

August
1975
Vol. 68, No. 8

of the Oklahoma State Medical Association

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Education of the Coming Generation of Physicians

(These remarks, made by Ernest Lachman, MD, on the occasion of his induction into the Oklahoma Hall of Fame, November 16, 1951, are as pertinent today as they were more than twenty-three years ago. Ed.)

The subject, which I have chosen for these short remarks, pertains to the education of the coming generation of physicians. Medical education is a field with which I have been connected for the last twenty-five years and in three different countries.

My observations are neither particularly profound nor probably very original. They can be summarized in the rather trite statement that physicians should practice in the conduct of their own life what they counsel their patients to do and that medical school is the place to indoctrinate students accordingly. Permit me to elaborate on this.

We know that more than 60 percent of the ailments which we see in our patients, are connected with the stresses and strains of everyday life and work. We suggest to our patients a change of their daily program and a different philosophy of life. We tell them that they should have regular periods of relaxation alternating with their work and that they should take time out for rest and thoughtful reflection. We advise them to indulge in hobbies and widen their fields of interest beyond and outside the tension producing atmosphere of their work.

Medical schools all over the country are going through a phase of optimistic reorganization, curricula are being revised and physical facilities enlarged everywhere. American medical scientific training is leading in the world today.

Should we not, during this productive period, when our thoughts on medical education have not completely crystalized, incorporate some of these ideas in our program, so that they may influence the student during his formative years?

Should we not provide the external facilities for physical exercise and relaxation, such as playgrounds and swimming pools, tennis courts and gymnasias, libraries and lounges? More important, should we not encourage our students to cultivate broader interests, should we not stimulate their literary and musical inclinations and foster an interest in the issues of today?

The foundation is there: a medical school is part of a university, and the university is the place to expose students to a philosophy of life that allows for happiness and peace of mind beyond material success.

I need not belabor this point any further, but I would like to add one more thought, only loosely connected with the preceding observations.

If we compare the authorship of articles in our medical journals today with papers written thirty or forty years ago, we notice that joint authorship has become more and more common. Teamwork in medical research and teamwork in medical practice, as expressed in partnerships and frequent consultations among physicians, are a characteristic feature of medicine today. It is through the cooperative endeavor of scientists in different fields, that medicine advances.

Again we should start with the medical student, and encourage team work and joining of effort in our schools.

If we incorporate some of these thoughts in our educational program, we will be training a generation of physicians, fully aware of the needs of our time. *Ernest Lachman, MD*

"Regulations or Laws?"

I feel that the most pressing issue in Oklahoma medicine today is Section 224 of Public Law 92-603 that was passed in 1972. This section of the law was not implemented until July 1st, 1975. By the time this page is read by our members the law will be in full operation. This law like many others was implemented at the direction of Secretary Caspar Weinberger. It provides for a cutback of Medicare and Medicaid reimbursements. The law provides for a rollback of the reimbursements to the amount that was being paid in 1969 and 1970. The secretary has now ruled that the maximum increase in the Medicare and Medicaid reimbursements will be only 17.9 per cent over the year of 1969. This represents only three per cent per year in the last six years. This is a completely unfair reduction, when we consider that the cost of living has increased much more than that.

In announcing the reimbursement rollback the Secretary of HEW stated that it will save the federal government approximately \$26 million during the fiscal year 1976. What the secretary failed to point out was that this \$26 million will have to be paid out of the pockets of the Medicare and Medicaid patients.

Our Public Policy Council appears to have, after many hard weeks of study and work, come up with a workable solution to the Utilization Review problem. This council has written a new type program called "Cost Control Program for Hospitals." The program contains the desirable characteristics such as physician educational benefits, physician control, no



physician penalty for the physician who is doing a good job, and no patient penalty; but it does have a penalty clause for the deviant physician. It appears at this time that the Oklahoma plan will be approved as a superior plan and be implemented in Oklahoma instead of the Federal Regulations.

It is quiet possible that the Oklahoma plan will be used as a demonstration project. If this is actually accomplished, it is possible that we will receive substantial funding for the expense of such a demonstration project.

Some of my close friends have been critical of me and critical of our association for opposing the Utilization Review regulations of November 29th, 1974. I have felt that it is my duty to inform them that the regulations are not law. Legislation by regulation is one of the big problems that this country faces. The Congress, too many times, has written into federal statutes discretionary authority to various secretaries for making rules and regulations to implement the law. The net effect has been that non-elected federal employees unilaterally write regulations that are not in keeping with the intent of Congress. Senator Henry Bellmon feels so strongly about this that he has introduced legislation requiring regulations to be submitted to the Congressional Committee that originated the legislation. It is absolutely imperative that physicians and other citizens of this great country express themselves when their rights are violated by the federal bureaucracy. It is indeed a dangerous situation when a leading segment of society sits back and does nothing when regulations are written that so seriously affect the sick people of this country. We should all fight for the rights granted us by the United States Constitution and the United States Congress.

Arnold G. Nelson, M.D.

Community Genetics I

JAMES G. COLDWELL, MD
BURHAN SAY, MD
KATHRYN JONES, BS

Genetic problems occur with great frequency in the general population with one out of each one-hundred newborns having either a chromosomal defect or a major gene abnormality. A community resource has been developed.

The purpose of this report is to describe a portion of a program to provide genetic services for a community. Cytogenetics have not been generally available in Tulsa. Equipment was purchased with Mental Retardation monies, provided through the Maternal and Child Health Division of the Oklahoma State Department of Health. The program is located at Children's Medical Center (CMC), Tulsa, Oklahoma, which is a specialized hospital. The majority of the children have neurological disorders, emotional problems, chronic illness, mental retardation, or genetic disorders. Genetic services became fully available in January, 1974. The services provide chromo-

some studies, dermatoglyphic analysis, and syndrome identification as well as genetic counseling. Laboratory facilities available include a cytogenetic laboratory and a metabolic laboratory which deals mainly with disorders of amino-acid metabolism. In the cytogenetic laboratory, an MD clinical geneticist and two technicians study patients from CMC as well as those referred by outside physicians. The genetic service is part of the Pediatrics Department.

During 1974, 136 patients, of which 22 were parents, sibs, etc, were studied for possible chromosomal aberrations. Table 1 shows a breakdown of these cases with regard to their age, sex, and source of referral. Although at the beginning the majority of the patients were from CMC, the ratio gradually changed in favor of those referred by outside physicians. Most of the 114 probands studied were under 16 years of age and only 10% of the total number of patients were older than 16 years. (Table 2) It is interesting to note that the overall percentage of abnormalities encountered is 20%, which is about 40 times higher than that

Table 1

Number of Chromosome Studies	136
Patients	114
M—63	
F—51	
CMC—54	
Referrals—60	
Parents, Sibs., etc.	22

From the department of Developmental Medicine and Child Neurology, Children's Medical Center, Tulsa, Oklahoma 74105

Table 2, Age Distribution (114 Pts.)

	Normal (% 80)	Abnormal (% 20)
0—12 mos.	30	10
1—6 yrs.	24	2
7—16 yrs.	30	7
>—16 yrs.	8	4
	<hr/> 92	23

expected in the live-born newborn population.¹ This, of course, indicates a careful selection by the referring physicians before ordering chromosome studies, still a relatively costly procedure. Another interesting point in this respect is the high percentage of abnormalities (33%) observed among those over 16 years of age which may be due partly to the fact that adolescent and adult patients are not usually referred here for studies unless they have significant findings pointing to the possibility of a chromosomal aberration such as amenorrhea, short stature, delayed puberty, or abnormalities of the external genitalia.

Among the 136 patients on whom cytogenetic studies were carried out, 23 (20%) showed various abnormalities. As expected, Down's syndrome (Trisomy 21) and Turner's syndrome (45, XO) were the most common entities. (Table 3) Although, as seen in Table 4, XYY karyotype is rather commonly encountered among the newborns, in our series we did not have any patients with this chromosomal aber-

James G. Coldwell, MD, graduated from the University of Oklahoma College of Medicine in 1955. He is a member of the American Academy of Pediatrics and the American Society of Human Genetics.

Since his graduation from the School of Medicine, University of Istanbul in 1946, Burhan Say, MD, has been certified by the American Board of Pediatrics. He is a member of the European Society of Hematology and Immunology and the European Society of Teratology.

Mrs. Kathryn Jones, BS received her certification in medical technology in 1967 and her Bachelor of Science in horticulture from Oklahoma State University in 1974. She is chief technologist in the cytogenetic laboratory, Children's Medical Center, Tulsa, Oklahoma.

Table 3
Abnormal Karyotypes Encountered (23 pts.)

Trisomy G	7
Mosaic Trisomy G	1
Trisomy D	1
Trisomy C	1
Cri du Chat	1
Extra Metacentric Chr.	1
Translocation (3/15)	2
Turner's Syndrome	6
Klinefelter's Syndrome	3

ration. This is probably due to the fact that the patients with XYY karyotype rarely show easily recognizable clinical stigmata such as do those seen in Turner's syndrome. Although in the past it was suggested that XYY patients are quite tall and have somewhat antisocial behavior, these claims have recently been strongly disputed by various authorities.² Finally, it can also be argued that the rather small number of patients so far studied may be the main reason for not observing a case, as yet, with XYY chromosome constitution.

There were three patients in this series with interesting karyotypes. One of these involved a newborn infant who lived only a few days after birth. He had 46 chromosomes plus a small metacentric chromosome, the origin of which

Table 4, Chromosome Abnormalities in Newborns¹
(31,801 Consecutive Newborns)

Sex Chromosome Abnormalities	Per 1,000
45,XO	0.15
47,XYY	1.21
47,XXY	1.29
47,XXX	0.89
Others	0.40
Autosome Trisomies	
D+	0.14
E+	0.11
G+	1.06
Others	0.04
Autosomal Structural Abnormalities	
D/D Translocation	0.72
D/G Translocation	0.22
Other Balanced Translocations	0.75
Unbalanced Translocations and Deletions	0.25
Pericentric Inversions	0.16
Extra Small Chromosomes	0.22
Others	0.03
TOTAL	<hr/> 5.72



Fig. 1. Karyotype of the patient

could not be established in spite of the use of newer techniques such as fluorescent and giemsa banding. Chromosome studies were also done on the parents, as well as the stepbrother, but with normal findings. It is interesting that in the few such patients which have been reported in the past, the origin of the extra chromosome likewise could not be established. Clinically, the patient showed many findings resembling those seen in 18 Trisomy, which was the clinical diagnosis put forward by Dr. Martin Greenberg, the referring physician. A full description of this patient will be reported elsewhere.³

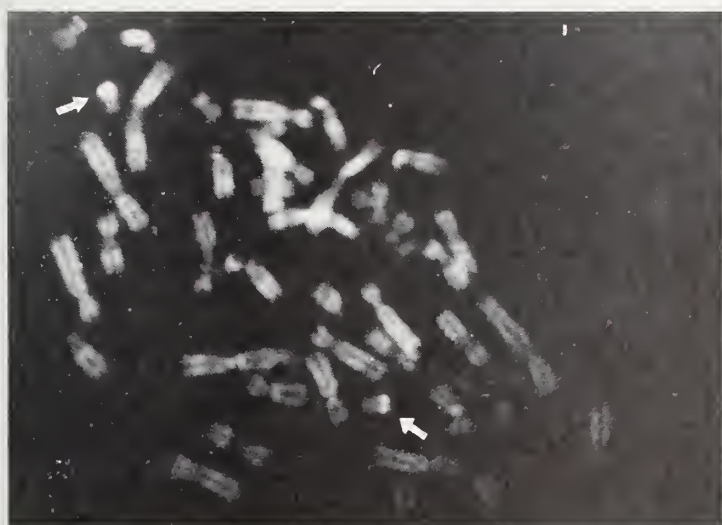


Fig. 2. A. Karyotype of the patient.
B. Arrows point to the two Y chromosomes. (Q banding)

Another interesting chromosomal aberration was observed in a family in which two mentally retarded siblings were found to be trisomic for a part of the short arm of chromosome 3 while the mother had a balanced translocation between chromosome 3 and 15. It is quite likely that partial trisomy for the upper arm of chromosome 3 may constitute a new chromosomal syndrome.⁴ A review of the previously reported cases with similar chromosomal aberrations indicates that there are certain congenital malformations which are common to most of them involving the cardiovascular and genitourinary systems. A detailed report for publication is being prepared and will be published elsewhere.⁴ Since the chromosomal aberration seen in the family provided a unique opportunity for possible assignment of genes to the deleted portion of chromosome 3, skin samples were obtained from the patients and were sent to Children's Medical Center in Boston. It may be mentioned here that no definite gene assignment has been made to the number 3 chromosome as yet.

Finally, the last patient with some cytogenetic interest involved a mentally retarded adult in whom chromosome studies revealed an XXYY karyotype. (Figure 2)

During the past 12 months, many hereditary conditions were observed in which chromosome studies were normal. Some of these were well-described entities. However, there were three families which were of special interest to us. One of these was a family, four members of which had isolated cleft palate in association with small head size, large ears, and short stature as cardinal findings. It appears that this constellation of anomalies represents a hitherto unreported entity.⁵

We were able to study another family, four members of which had double triphalangeal thumbs in association with brachydactyly, camptodactyly, subluxation of the patella, short stature, and borderline intelligence. After reviewing the literature, we came to the conclusion that this family also represents a new dominant (autosomal or x-linked) entity.⁶

Finally, a four-year-old girl was studied here with the chief complaint of urinary incontinence associated with partial sacral agenesis. Further studies indicated that the patient's mother as well as one of the female siblings had similar sacral defects.⁷ A search of the literature revealed that a similar family has been studied previously by two Danish workers who proposed an x-linked dominant inheritance for

this anomaly.⁸ It seemed to us that the findings in the family we studied supported their contention. In view of the fact that there were multiple stillborn males born to this mother, we suggested that the gene in question may be lethal in the hemizygous male. All of these families are in the process of being reported.

SUMMARY

The utilization of a genetic clinic has been described. The positive results demonstrate its need and its value to the community. Other activities of the program will be described in subsequent papers. Further development of the program is planned as resources, primarily financial, become available.

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Children's Medical Center, P.O. Box 35648, Tulsa, Oklahoma 74135.

LETTER

Editor

Journal of the Oklahoma State Medical Association
601 Northwest Expressway
Oklahoma City, Oklahoma 73118

On page 215 of the July, 1975 JOURNAL ("Yesteryears' Diagnosis"), Doctor Ed L. Calhoon calls attention to the Nannie Doss case in Tulsa and refers to "a young physician in Tulsa, Dean Hyde, MD." The physician referred to is actually W. Dean Hidy, MD, a Tulsa surgeon. Doctor Leo Lowbeer, the pathologist at Hillcrest Hospital, suspected arsenic poisoning from observations he had made and later confirmed this diagnosis to the satisfaction of the Court.

As Doctor Calhoon implies the Nannie Doss case was of great import in the 1961 statutes concerning unexplained deaths.

Walter E. Brown, MD
Tulsa
WEB: daf

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Dosage and administration: Lomotil is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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the agency saying, "this informa-
tion is generally agreed upon and
it should be used," as long as
the process for getting the infor-
mation is sound.

Distribution of the information is
a problem. In great measure it
will depend on the medication in-
volved. For example, in the case
of injectable long-acting proges-
terone, we would think it mandatory
to have two separate leaflets—a
one for the patient to read be-
fore getting the first shot and a long
one to take home in order to make a
decision about continuing therapy.
In other cases, the information might
be printed directly on the package
and be removable at all. But for a medi-
cation like an antihistamine this
information might be issued sepa-
rately, thus giving the physician the
choice of distribution. This could
include the placebo use, etc.

It is in the distribution of pa-
tient information that the pharma-
cist may get involved. As profession-
als and members of the health-care
team and as a most important source
of drug information to patients,
pharmacists should be responsible
for keeping medical and drug rec-
ords on patients. It is also logical
that they should distribute drug in-
formation to them.

Realistic problems must be considered

We have to expect that the in-
troduction of an information device
will also create new problems. First,
how can we communicate complex
and sophisticated information to
people of widely divergent socio-
economic and ethnic groups? Sec-
ond, what will we say? And third,
how can we counteract the negative
attitude of many physicians toward
any outside influence or input? Hope-
fully the medical profession will re-
spond by anticipating the problems
and helping to solve them. Assum-
ing we can also solve the difficulty
of communicating information to di-
verse groups throughout the United
States, our remaining task will be
the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chem-
ical and such types of material
should not be included. And there is

no point in the routine listing of side
effects like nausea and vomiting
which seem to apply to practically
all drugs, unless it is common with
the drug. However, serious side ef-
fects should be listed, as should in-
formation about a medication that
is potentially risky for other reasons.

Other pertinent information
might consist of drug interactions,
the need for laboratory follow-up,
and special storage requirements.
What we want to include is informa-
tion that will help increase patient
compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the
patient would accomplish a number
of good things: the patient could be
on the lookout for possible serious
side effects; his compliance would
increase through greater under-
standing; the physician would be a
better source of information since
he would be freer to use his time
more effectively; other members of
the health-care team would benefit
through patient understanding and
cooperation; and, finally, the physi-
cian-patient relationship would prob-
ably be enhanced by the greater
understanding on the part of the pa-
tient of what the physician is doing
for him.

The doctor can remove that fear
of 30 minutes of conversation.
I am not suggesting that we
hide any information from the
patient because, first of all, it would
be dishonest and secondly, it
defeat the very purpose of the
insert. I do think that a patient on the
control pill should know about
the incidence of phlebothrombosis.
If you're going to tell a patient
the incidence of serious adverse re-
actions, then you have to tell him
the concerned medical decision
made to use a particular medi-
cation in his situation after careful
evaluation of the incidence of
reactions or side effects.

Emotionally unstable patients pose a special problem

There are patients who, be-
cause of severe emotional problems,
cannot handle the information
presented in a patient package in-
sert. If we are going to have a
package insert at all, we just can't
have no inserts. I think we might
have to tell the families of
patients to remove the insert
from the package.

Implications of the patient package insert

Just what effect would a pa-

tient package insert have on mal-
practice? We could try to avoid any
legal implications by pointing out
that the physician has selected a
particular medication because, in
his professional judgment, it is the
treatment of choice. For instance,
you can't tell everyone taking anti-
histamines not to work just because
a few patients develop extreme
drowsiness which can lead to acci-
dents. And what about the very small
incidence of aplastic anemia rarely
associated with chloramphenicol?
If, based on sensitivity studies and
other criteria, we decide to employ
this particular antibiotic, we do so
in full knowledge of this serious po-
tential side effect. It's not a simple
problem.

How do we handle an insert for medi- cation used for a placebo effect?

With rare exceptions, physi-
cians no longer use medications for
a placebo effect. This question does
raise the issue of how a patient may
react to receiving a medication
without a package insert.

Preparation of the package insert

The development of the insert
ought to be a joint operation be-
tween physicians, the pharmaceu-
tical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a co-
ordinator or catalyst. It is the only
organization through which the pro-
fession as a whole, irrespective of
specialty, can speak. It has relatively
instant access to all the medical ex-
pertise in this country. And it can
bring that professional expertise to-
gether to ensure a better package
insert. The A.M.A. can work in con-
junction with the industry that has
produced the product and which is
ultimately going to supply the insert.

I don't think we should rely, or
expect to rely, on legislative com-
mittees and their nonprofessional
staffs to make these decisions when
it is perfectly within the power of
the two groups to resolve the issues
in the very best American tradition—
without the government forcing us
to do it. I think the F.D.A. has to be
involved, but I'd like them to become
involved because they were asked
to become involved.

Pharmaceutical
Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005



Projecting the Estimated Needs for Internists in Oklahoma Through the Year 1990

A TASK FORCE REPORT OF THE OKLAHOMA SOCIETY OF INTERNAL MEDICINE

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The Department of Internal Medicine, University of Oklahoma School of Medicine requested that the Oklahoma Society of Internal Medicine attempt to ascertain the need for the services of Internal Medicine specialists over the next twenty-year period, in order that some attempt could be made to satisfy these needs through training programs offered at the school. The Task Force which was created felt that consideration should be given to the abso-

lute number of Internists available to the state consumer; the specific types of sub-specialty personnel available, and the distribution of these Internists in the various geographic areas of Oklahoma.

The data for these projections were obtained from pertinent medical literature, a survey of practicing Internists in Oklahoma, and population projections obtained from the Research Department of the Employment and Securities Commission of the State of Oklahoma.

The Task Force is well aware of the difficulties in arriving at such projections. The data presented must be viewed as preliminary, and based upon the best available methods of estimating these future demands. In reviewing the current medical literature, we were impressed with the number of articles expressing opinions about the need for physician specialists. However, there is a shortage of hard data available that is of assistance in arriving at accurate estimates.

To initiate this prediction, we felt we must know the present role of Internists in providing medical services to Oklahomans: In 1970, there were 2,528 actively practicing physicians in Oklahoma, of which 350 identified themselves, for American Medical Association records, as being engaged primarily in the practice of Internal Medicine. Thus, in the year

1970, there was one internist per 7,312 people in Oklahoma. In order to ascertain the age, location and type practice these Internists were engaged in, we distributed a questionnaire. We obtained 240 completed questionnaires upon which we base our data.

As far as age is concerned, there are 86 Internists in the 30-39 year age group; 62 in the 40-49 year age group; 64 in the 50-59 year age group; 18 in the 60-69 year age group and two physicians over the age of 70. Age distribution is essentially the same in urban and non-urban areas.

Of the 240 physicians responding, we found that 170 practiced in the urban areas, or in cities of 100,000 population and above (meaning, Oklahoma City and Tulsa). We found that 100 physicians feel that 60% or more of their practice consisted of sub-specialty endeavors. Thus, 42% of the Internists in Oklahoma practice primarily sub-specialty medicine. On the other hand, if we analyze the sub-specialty practices as to community size, we find that 84 of the 100 physicians who practice sub-specialty medicine, do so in urban areas of greater than 100,000 population. One hundred seventy-six Internists felt that their practice was "primary care" oriented, which comprised 75% of the Internists completing the questionnaire. We made no effort to define the term "primary care" in the questionnaire.

The summary of the data then would indicate that Oklahoma has one Internist for every 7,312 persons: that 71% of the Internists practice in urban areas which comprise only 25% of the State's population; that a significant number (42%) of these Internists do primarily sub-specialty practice (these are also predominantly in the urban areas), and that almost three-fourths (72%) of the Internists consider their practices "primary care" oriented.

The optimal ratio of internists per population is not well established. However, at the present time, there are several estimates based upon programs that seem to satisfy the consumer's demand for Internists' services. For example, the Baltimore urban area is felt to be well-supplied with medical services and the present demand for physicians' services seems to be met in this area about as well as anywhere in the United States. The number of Internists per population ratio is one per 4,338 persons. When this is broken down into types of practice the "primary care" Internists ratio is 1:5,260. In the Internal Medicine sub-

specialties, the ratio is approximately 1:22,000.

A survey was recently published comparing the prepaid medical service groups over the country and the categories of physician specialists. Analyzing these data it would seem that the optimal Internist per subscribing member ratio is one per 4,000 members. (It must be pointed out that these ratios apply to demands as they existed in 1970. With the advent of social change in the method of purchasing health services, as well as the advancing sophistication of medical services provided, and the education of the consuming public, these demands will increase at an unpredictable rate).

If we apply the ratio of one Internist per 4,000 population as being optimal, at the present time, Oklahoma should have 648 practicing Internists. We have 350, leaving a deficit of 298 needed to achieve this optimal ratio. Projected population estimates for Oklahoma in 1990 are 3,089,400, which is a net gain of 430,000 population. It would take another 107 Internists to fill the need of this increased population. If these deficits are to be made up over a twenty-year period, it would require 21 new internists per year over the normal attrition rate. If we use the normal attrition rate (death and retirement) Oklahoma will lose 20 Internal Medicine Specialists per year. Therefore, a total of 41 Internists should be trained each year over the next 20 years to provide the optimum ratio of one Internal Medicine Specialist per 4,000 population. As noted previously, this does not take into account any increase in demand for Internists' services over what appears to be optimal in 1970.

Attempting to arrive at a conclusion as to how many and what type sub-specialists in Internal Medicine should be available for Oklahoma is even more difficult. The only data that we would have to base an opinion on would be the Baltimore Urban-area study which considered a ratio of one sub-specialist to 22,000 population as ideal. Using this figure, we would project that, in the year 1980, we should have 127 sub-specialists in Oklahoma and by 1990 we should have 140. These projections, however, are based upon data already ten-years-old and with the continuing sophistication of medical technics, we are sure that they are quite inadequate. Certainly the training programs in sub-specialty fields should not be curtailed at this time because the need for general Internists seems to be the greatest prior-

ity. The distribution of the various sub-specialties in Oklahoma, at the present time, consists of 43% in cardiology, 9% in chest disease, 7% in allergy, 7% in oncology, 7% in gastrointestinal diseases and 27% in other sub-specialties. Whether this represents an optimal distribution among these sub-specialties cannot be determined by this survey, and we could find no reasonable estimate as to an optimal ratio.

As has been pointed out, 42% of the physicians practicing Internal Medicine in Oklahoma, at this time, are in sub-specialties and the optimal ratio would appear to be closer to twenty-five per cent. Serious consideration should be given to encouraging and designing training programs that provide a broad-based knowledge of adult medical practice. The pres-

ent sub-specialty program should not be curtailed, however, the young internists should be equipped for a primary non-referral-type medical care practice which appears to be the most pressing need in our State at this time. Also attempts should be continued to correct the apparent mal-distribution of Internists' services to various population groups in Oklahoma. The Department of Medicine at the Oklahoma Health Sciences Center is actively engaged in exploring methods of correcting this mal-distribution at the present time.

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4. Population Estimates for Oklahoma, Personnel Communications Research Department, Employment Securities Commission, State of Oklahoma, and "Penalogical Survey," 1972, Oklahoma Society of Internal Medicine. 601 N.W. Expressway, Oklahoma City, Oklahoma 73118

Continuing Education for Medical Assistants

The Oklahoma Chapter of the American Association of Medical Assistants, Inc., State of Oklahoma, Inc., in conjunction with the Department of Continuing Education at Oklahoma University, is sponsoring a series of six seminars for medical assistants.

Registration is \$15 per program for members and \$18 for non-members or \$75 for the entire series for members and \$90 for non-members. Reservations should be directed to Education and Certification Committees, AAMA, Inc., State of Oklahoma, Inc., 4200 West Memorial Road, Oklahoma City, Oklahoma 73120.

PROGRAM

September 6th: Expectations of the Physician
Telephone Techniques
Telephone Problems
October 18th: Written Communications
Bookkeeping
Indexing and Filing
Mailing Services
December 6th: Examining Room Techniques
Sterilization
Care of Equipment

Emergencies
Injections and Medications
January 17th: Preparing the Standard Operating Procedure Manual
February 21st: Laboratory Procedures
Immunology
Physiotherapy
X-Ray
April 10th: Medical Ethics
Law and Economics
Medical Records
Credit and Collections

The Venereal Disease
Program Representative

Many venereal disease cases in Oklahoma are treated by private physicians, and reporting of private cases is becoming more complete. More accurate disease trend information facilitates better targeting of limited program resources. Identification and treatment of sexual contacts of known cases is one key to controlling venereal disease. Most physicians do not have time to do a thorough epidemiologic investigation of each venereal disease case they treat.

When a new case is reported, the reporting facility is contacted to obtain additional information which will assist the investigator. No individual known to be under private care is ever contacted without the express permission of the private physician involved.

The program representative is specially trained to interview for names and locating information for all critical-period sexual partners. He describes the health department's function and discusses modes of transmission, incubation period, symptomatic/asymptomatic infections, and possible consequences of untreated infection.



News From
The Oklahoma State
Department of
Health

The investigator confidentially contacts each person named. The identity of the original patient is protected. If a contact elects to be seen by his or her private physician, their doctor is alerted and epidemiologic treatment is suggested if this preventive procedure is indicated.

Services from program representatives are available in every county in the state. This includes darkfield examinations, which can be performed in the private physician's office on relatively short notice.

If you have a specific problem, need to know how to obtain services, or simply want to meet your representative, please contact the Venereal Disease Control Program at the Oklahoma State Department of Health. The "traditional" venereal diseases *can* be controlled as we work toward the eventual eradication of all sexually transmitted diseases. □

COMMUNICABLE DISEASES IN OKLAHOMA FOR JUNE, 1975

DISEASE	JUNE 1975	JUNE 1974	MAY 1975	Total To Date	
				1975	1974
Amebiasis	3	3	2	9	10
Brucellosis	—	2	1	3	4
Chickenpox	37	94	213	924	789
Encephalitis, Infectious	4	16	1	19	31
Gonorrhea (Use Form ODH-228)	1112	904	940	6121	5227
Hepatitis, A, B, Unspecified	72	78	54	441	565
Leptospirosis	—	1	—	—	1
Malaria	—	—	—	1	1
Meningococcal Infections	1	1	—	9	12
Meningitis, Aseptic	5	7	4	18	27
Mumps	18	42	51	149	350
Rabies in Animals	7	22	11	65	86
Rheumatic Fever	—	—	1	6	7
Rocky Mountain Spotted Fever	25	18	21	50	28
Rubella	2	4	14	82	33
Rubella, Congenital Syndrome	—	—	—	1	1
Rubeola	26	4	72	116	23
Salmonellosis	18	12	16	86	119
Shigellosis	12	19	7	167	75
Syphilis, Infectious (Use Form ODH-228)	4	5	2	42	75
Tetanus	—	—	—	—	—
Tuberculosis, New Active	37	35	28	174	153
Tularemia	3	3	3	5	6
Typhoid Fever	—	—	—	—	—
Whooping Cough	3	2	1	15	8

For Consultation Call: (405) 271-4060

A Summary of Medical Legislation Introduced in the 1st Session of the 35th Oklahoma Legislature

INTRODUCTION

Oklahoma lawmakers were two days short of the Constitutional limit when they adjourned on June 6th. Eighty-eight legislative working days produced almost four hundred new laws. Eleven hundred and seventy seven proposals were introduced. Medical and medical-related bills accounted for roughly ten per cent of the total. Medical education, rural health problems and medical-legal issues received the most attention. Seven hundred twenty six bills will be carried over into the Second Session of the Thirty-fifth Oklahoma Legislature. Following is a summary of the most important laws enacted and a review of those bills to be considered next session.

Internship and Residency Bill. Probably the most significant new medical law is HB 1552 which allocates funds for internship and residency programs. The act creates a seven member Physician Manpower Training Commission, to be appointed by the Governor, six of whom must be physicians. In addition, there are eight ex-officio members who serve in an advisory capacity. They are to represent the colleges of medicine and osteopathy, the medical, osteopathic and hospital associations, the Health Planning Commission and University Hospital's Board of Trustees. The commission total is fifteen.

The primary purpose of the legislation is to encourage the development of medical education programs outside Oklahoma City and Tulsa.

The commission is charged with the responsibility of reviewing data to establish the need for additional health manpower by location and by specialty. They will assist hospitals and

communities in organizing programs that can be accredited. The emphasis is to be on the primary care specialties defined as internal medicine, obstetrics and gynecology, pediatrics, emergency trauma and family practice. The commission will determine the amount a hospital may be paid for conducting an approved program, but it shall not exceed \$6,000 per student.

The new law also permits a community to enter into a contract with the commission for financing a resident's training. A practice agreement would be part of the contract.

Initial funding of the new program is \$264,000, however the legislature was presented budget projections indicating the program could cost up to three million by 1980. A portion of the money must be spent on rural programs — in FY 1975 5% — but by 1980 40% of the money must be spent in rural areas.

Prescription Drug Program. Oklahoma's Department of Public Welfare could spend up to nine million dollars during the next year for prescription drugs. A vendor drug program authorized by the legislature allocates three million in state funds to initiate a plan to assist welfare recipients with ". . . painful or life endangering diseases." Anticipated federal matching monies will be six million dollars.

Physicians were officially notified of the program in mid-June by Lloyd Rader, Director of the Department of Institutions, Social and Rehabilitative Services. Recipients are limited to three prescriptions per month in designated categories. Properly prescribed, the department will pay for antibiotics, antibacterials, antineoplastics, analgesics and a broad range of cardiovascular drugs. In addition, insulin

and birth control pills are covered. The letter to physicians explaining the program encourages generic prescriptions ". . . consistent with quality standards," but permits trade name prescribing if the physician prefers.

Those eligible for the program will receive a card from DISRS each month entitling them to three prescriptions which can be for 100 dosage units or a 34-day supply, whichever is greater. Prescriptions written by licensed physicians, dentists and podiatrists will be honored.

Members of the Oklahoma Pharmaceutical Association have received a formulary prepared by their association. While not official, Tate Taylor, Executive Director, feels most drugs covered by the program have been listed.

Health Maintenance Organizations. A federal law passed in 1973 authorized funding for Health Maintenance Organizations but Oklahoma's insurance code has effectively stopped efforts to start such operations in the state. Two studies — one in Tulsa and another in Okemah, while not endorsing the HMO concept, did point up the need for special enabling legislation. Senate Bill 243 authorizes the Health Planning Commission to issue a license to an organization that meets the fiscal and fiduciary tests of the State Insurance Commission. Another act requires the HMO to justify the need for its existence to the Health Planning Commission. Rules and regulations governing the operations of the HMO are to be promulgated by the Health Planning Commission who are ". . . to protect the public, insure the sound, proper and efficient operation of health maintenance organizations in this state." Strict advertising restrictions are set forth to prohibit deceptive or untruthful statements. While enrollment procedures are not specified in the bill, cancellation of coverage is prohibited except for failure to pay.

The Oklahoma Health Planning Commission is currently composed of R. LeRoy Carpenter, MD, Commissioner of Health, Hayden Donahue, MD, Director of Mental Health, and Lloyd Rader, Director, Department of Institutions, Social and Rehabilitative Services.

Minor Consent Law. After years of debate about the capacity of a minor to consent for medical treatment, the Oklahoma Legislature has passed an omnibus bill granting broad rights to minors and physicians. House Bill 1537 states that the following minors may consent to have services provided by health professionals:

"Any minor who is or has been married, has

had a child, graduated from high school or is emancipated; any minor who is separated or alienated from his parents, or legal guardian for whatever reason or is supporting himself; any minor who is pregnant, affected with any reportable communicable disease, drug and substance abuse or abusive use of alcohol; any minor as to his child; any minor who by reason of physical or mental incapacity cannot give consent and has no known relatives or legal guardian, if two physicians agree on the health services to be given; or any minor may receive non-emergency services for conditions which will endanger his health or life if delay would result by obtaining consent from his spouse's parent or legal guardian."

Health services are defined to include examination, preventative and curative treatment, surgical, hospitalization, and psychological services, except abortion or sterilization.

Notification of parents, guardians or spouse is left to the judgment of the person delivering the care, as specified in the bill ". . . the health professional may, but shall not be required to inform . . . 'and' . . . the judgment of the health professional as to notification shall be final. . . ." No civil or criminal acts can result from disclosure or the lack of disclosure except for negligence or intentional harm.

Parents, guardians and spouses are exonerated from liability for the payment for services unless they agree to pay.

Emergency care in a life threatening situation requires the concurrence of another physician, if one is available, or a parent, spouse or guardian if the minor is unable to consent.

For the purposes of the Act, Health Professional is defined as ". . . any physician, psychologist, dentist, osteopathic physician, registered or licensed practical nurse, physician associate or counselor employed by an agency licensed under the Oklahoma Child Care Facilities Licensing Act.

Peer Review Immunity. Physicians serving on peer review committees are granted immunity from liability for damages that may arise as a result of any actions the committee takes. The law — House Bill 1277, requires that the committee be affiliated with the American Dental Association or the American Medical Association. Subjects for review are ". . . complaints concerning services, fee, payments or utilization . . ." Committee

members must act without malice and in the best interest of the public.

Certificate of Need. New institutional health services will require approval of the Oklahoma Health Planning Commission. Senate Bill 278 declares that it shall be the policy of the State that development of new institutional health services should be made in an orderly and economical manner consistent with the needs of various areas of the state. To implement the policy the Legislature has vested in the Health Planning Commission the right to issue "certificates of need." Services that require the advance approval are primarily those that are provided through hospitals. However, the language of the law extends to ". . . other health care facilities and health maintenance organizations and entities through which such services are provided . . ." Nursing homes and physicians' offices are not covered by the Act.

Criteria for determining need is to include ". . . the adequacy of institutional services in the locality, the availability of services which may serve as alternatives or substitutes, the adequacy of financial resources for the new services and the availability of sufficient manpower to properly staff and operate the proposed new services . . ." Violation of the law is a misdemeanor.

Death Definition Revised. A law revising the definition of death establishes brain function as the basic criteria. The statutes prior to the new law were vague and left physicians subject to legal challenge about the time of death. Some physicians and institutions involved in transplant operations felt uncomfortable about their liability under the old act. A dead body is now defined as ". . . a human body in which there is irreversible total cessation of brain function; and if, based upon ordinary standards of medical practice, during reasonable attempts to either maintain or restore spontaneous circulation or respiratory function in the absence of aforesaid brain function, it appears that further attempts at resuscitation or supportive maintenance will not succeed, death will have occurred at the time these conditions first coincide. Death is to be pronounced before artificial means of supporting respiratory and circulatory function are terminated and before any vital organ is removed for purposes of transplantation."

Impaired Drivers. Physicians are now immune from civil liability when they report

physically or mentally impaired drivers to the Department of Public Safety.

Traditionally, the medical profession has vigorously opposed legislation that interfered with the confidentiality of medical records or violated physician-patient relationships. However, Senate Bill 296 received the support of the medical association. Proponents of the bill felt that more impaired drivers would be reported if immunity was granted — opponents felt that the same people, afraid of being reported, would forego needed medical attention. On the first vote, the House rejected the bill 48-46. Three days later the vote was overturned and the bill passed 66-28. Essentially, the law provides that a physician may make a written report on the ability of a patient (when he is treating or has treated) to operate a motor vehicle. The report, nor action resulting from the report can be the cause of action against the physician. The law further provides that the department may, in its discretion, suspend or cancel the license for a period it considers justifiable.

Rural Loan and Scholarships. Several amendments were made to Oklahoma Rural Loan and Scholarship Program. Started six years ago, the fund has financed the medical education of a number of physicians who agreed, as a condition of participation to practice medicine in rural areas of the state. One year of service is required for each year of funding. No repayment is required if the service commitment is honored. Under the original law, the population ceiling was 5,000. The amendment raised the limit to 7,500. Maximum loan amounts have also been raised from \$5,000 to \$7,500. The Legislature has appropriated \$100,000 to the fund each year for several years but at Governor Boren's request, raised funding to \$200,000 for fiscal year 1975-76.

The most significant change in the law has been the governing board. The original law established a Rural Loan and Scholarship Board. Authority to operate the program has now been transferred to the new Physician Manpower Training Commission.

Insurance Coverage for Newborn. Health insurance benefits for a newly born child are guaranteed if the family has health insurance coverage. Some insurance policies did not cover newborn until certain periods of time elapsed — two, three days, etc. Now, however, companies writing insurance in Oklahoma must cover the child from the time of birth. The new

law, modeled after a uniform proposal written by the American Academy of Pediatrics, was supported by the Association.

Disabled Granted Treatment Rights. Persons with infirmities or disabling illnesses that wear identifying symbols are entitled to special treatment. A disabled persons Act sets forth the manner in which law enforcement officers are to treat persons ". . . unconscious, semiconscious; incoherent or otherwise incapacitated to communicate . . ." provided they are wearing the American Medical Association emergency symbol. The procedure requires that the officer make a diligent search for the identifying medal and identification card. If found, every effort is made to find the personal physician of the victim — failing, the officer transports the person to the hospital.

Objective of the law is to reduce the incarceration of the sick people. Several incidents have occurred when victims of epileptic seizure, diabetic coma and cardiac blackouts have been booked in jail with little or no effort to ascertain if the person was ill. The new law not only mandates the method of handling but also protects those that attempt to help the victim.

No Smoking. "Lighted tobacco in any form is a public nuisance and dangerous to public health . . ." so states the smoking ban proposed by the Oklahoma Lung Association. Legislators felt smoking was hazardous to your health but only in elevators, indoor theaters, libraries, art galleries, museums, concert halls and buses, and then only if "No Smoking" signs were posted. Final passage of the measure also permits smoking in adjacent rooms and separated areas if "Smoking Permitted" signs are posted.

Acupuncture. Limiting acupuncture to licensed physicians was attempted in Senator Frank Keathing's Senate Bill 398. Strong opposition from chiropractors resulted in the bill

being held over until next session. The bill, while very simple, is sure to create controversy. Rules and regulations governing the practice of acupuncture would be promulgated by the Commissioner of Health.

Medical Malpractice. The association sponsored five bills that are designed to reduce the number of claims filed and enhance the association attorneys' ability to defend personal injury actions. All will be considered next session. One proposal will permit a physician to file a counterclaim against his plaintiff and have the suit tried at the same time the action brought by the plaintiff is tried. Another of the five measures prohibits an action for breach of warranty unless the warranty is in writing. Reducing the time period for filing a claim is the objective of Senate Bill 450. The present statute of limitations would be reduced to one year from ". . . the date the claimant knew or should have known . . . and in no event . . . more than four years after the date of occurrence. . ." The other two measures provide for the admissibility of collateral sources and the manner in which the jury can be instructed. It is anticipated that medical malpractice will be a major subject during the second session of the 35th Legislature.

Workmen's Compensation. The disability insurance program for most Oklahoma's work force will undergo scrutiny this summer by a special Gubernatorial Study Committee. High rates, low benefits and fear of federalization precipitated the examination. Long criticized by labor, business and medicine, the program is overdue for revision. The association has advocated changes for years. A medical panel to review reports was offered during the Bartlett years. Resistance from Industrial Court Judges resulted in elimination of the panel. Hopefully, the new study will result in positive legislative action. □

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OSMA Distributing Medicare Cut Leaflet

A leaflet, designed to be sent out as a "statement stuffer," is being distributed by the OSMA to all of its members. The leaflet explains the reduction in Medicare benefits now being seen by Medicare beneficiaries.

In 1972, the United States Congress enacted Public Law 92-603. A portion of that law instructed the Secretary of Health, Education and Welfare to roll back Medicare payments toward doctor bills to the amounts physicians were charging in 1969 and 1970, plus a small yearly increase to be set by the Secretary. The law was not enforced until this year, when the Secretary issued implementing regulations.

The leaflet is designed to show Medicare recipients why the phrase "more than the allowable charge" is beginning to appear more and more often on their Medicare benefit explanation form. The leaflet reads as follows:

TO MY MEDICARE PATIENTS
YOUR MEDICARE BENEFITS ARE
BEING CUT

Your Medicare reimbursement is now being cut drastically! This reduction in Medicare benefits was brought about by the recent application of a 1972 federal law.

Public Law 92-603 instructed the Secretary of Health, Education and Welfare to roll back Medicare payments toward doctor bills to the amounts physicians were charging in 1969 and 1970, plus a small yearly increase to be set by the Secretary.

The Secretary has now ruled that the maximum increase in the Medicare reimbursement for physicians' fees will be only 17.9% over 1970 levels. This unfair reduction in your Medicare benefits is made all the more obvious when you consider that in the same time period the cost of living has increased more than 43%, housing costs have gone up more than 46%, the cost of transportation has increased 34% and food has increased 57%!

Because of this benefit reduction you will begin to see the phrase "more than the allowable charge" appear more often on your Medicare benefit explanation form. Please understand that the "allowable charge" referred to is the reduced amount that Medicare has decided it will pay for your medical care.

In announcing the reimbursement rollback the Secretary of HEW stated that it will save the federal government approximately \$26

million in 1976. What he failed to point out was that this \$26 million will have to be paid out of the pockets of persons on Medicare, the very persons that the program was designed to help.

The Secretary apparently ignored the fact that the Medicare eligible population of this country, those 65 years of age or over, are the ones traditionally living on a limited or fixed income.

If you are concerned, write your Congressman, U.S. Senators and the President of the United States in care of Washington, DC, to protect your interests.

One hundred copies of the leaflet were sent to every physician member of the OSMA for distribution to his Medicare patients. The production and distribution of the leaflet was made possible by the \$100 voluntary contribution made to the association by many of its members.

At the same time physicians were receiving copies of the leaflet for distribution, a news article went to every newspaper, radio and TV station in the state explaining the leaflet and its function. □

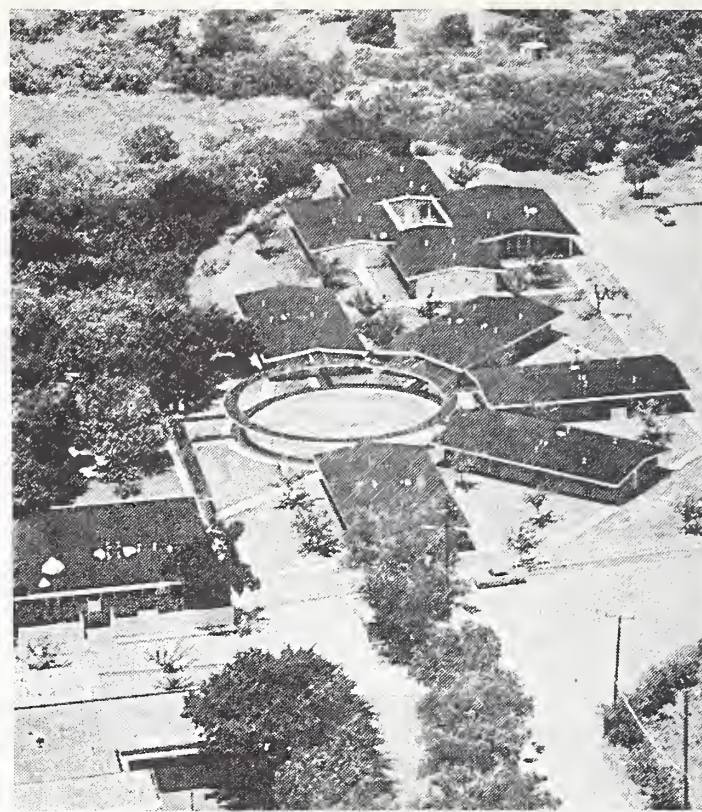
Two-State Cancer Forum Set For Fort Smith

Fort Smith, Arkansas will host the annual Kansas-Oklahoma Cancer Forum September 25th-26th. This year's program was developed in cooperation with the Memorial Hospital and Sloan-Kettering Institute of New York City.

The day and a half program concentrates on discussions dealing with the practical management of various types of cancer. The first presentation will begin at 8:30 the morning of September 25th in Fort Smith's Sheraton Inn.

Specialists in the field of pathology, colon surgery, breast surgery, gynecologic surgery, radial therapy, chemotherapy and immunotherapy will discuss recent advances in cancer management. The program also stresses early detection of breast cancer, psychiatric support of the cancer patient and rehabilitation of the patient.

Room reservations for the two days should be made directly with the Sheraton Inn, Fort Smith, Arkansas 72901. There is no registration fee for the program. All members of the medical profession, registered nurses and medical students are invited to attend. □



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Congressmen Debate HEW Regulations

A proliferation of unpopular regulations by the Department of Health, Education and Welfare resulted in an unusual one-day "public oversight" hearing by the House, Ways and Means Committee of the United States Congress. Purpose of the meeting was to determine if the Department of HEW had superseded congressional intent in an increasing number of Medicare costs-control regulations.

The subcommittee hearings, chaired by Dan Rostenkowski (D-Illinois) resulted in angry confrontations between the HEW Secretary and health care providers. However, undaunted by a solid array of heated opposition for medical hospital groups, Secretary Caspar Weinberger told the subcommittee that the four disputed Medicare regulations will save about \$250 million a year and "improve the quality of care."

Rostenkowski stated, "I hope the subcommittee can remove roadblocks. We should really try to get the government and the health care industry out of the courtroom and into the conference room where the debate belongs." His reference to the courtroom dealt with four lawsuits having been filed against the HEW Department to overturn the regulations.

The American Medical Association, along with other hospital and physician groups, urged the lawmakers at the hearing to crack down on HEW for going beyond the intent of law. At the same time Weinberger refused to acknowledge any merit in the private sector's attacks on the regulations and insisted that they followed the intent of Congress and were needed to curb costs.

The regulations under fire included the Social Security Utilization Review Plan requiring elaborate institutional post-admission review mechanisms; reducing the schedule of limits on hospital inpatient general routine service costs from the 90th to the 80th percentile; a limitation on recognition of physicians' prevailing charge increases, based on an economic index; and termination of the inpatient routing nursing salary cost differential in calculating hospital reimbursements.

Stressing a common theme among the witnesses, the AMA cited "a general feeling of futility concerning administrative action felt by the public as a whole, but especially by groups subject to and particularly affected by federal regulations." Ernest Livingstone, MD,

Chairman of the AMA's Council on Legislation, said many professional associations display "an attitude often of exasperation, consternation and indignation with respect to the bureaucratic administration of government programs." He went on to point out that administrative regulations often expand upon or entirely subvert the intent of Congress. This is why, he explained, the AMA for the first time in its long history has recently sued the HEW Department over the Utilization Review Regulations.

In reference to the Medicare reimbursement rollbacks, the AMA pointed out that HEW had barged ahead on the physicians Medicare fee index without giving interested parties a chance to question the details of the regulations. Edgar Beddingfield, MD, Vice-Chairman of the AMA Council on Legislation, said that there was no justification in either the law or its legislative history for imposing a national economical index. He then went on to note that Medicare fee recognition "has long lagged behind current trends in physicians' fees."

The Medicare fee index limits reimbursement to 17.9% above reimbursement levels prevailing in fiscal year 1973. The reimbursement level in that year was actually based on charges being made by physicians in 1969 and 1970. The new payment formula, according to Secretary Weinberger, will save the government an estimated \$26 million during this fiscal year. However, it has been noted that because of the fee rollback many physicians will refuse to accept assignments, and the \$26 million will have to be made up out of the pockets of Medicare recipients.

The AMA charged that Congress intended local, rather than national indexes, when it wrote the law and that the limitation was not supposed to be on a procedure by procedure basis but on an aggregate. They also charged that HEW allowed insufficient time for discussion on the matter in which it had decided to draw up the index. The AMA warned that the control would simply force more and more physicians to abandon the assignment method.

Other organizations, the American Hospital Association, in particular, testified regarding the other regulations.

In a separate action, the Association of American Medical Colleges has filed suit to prevent the Department of HEW from implementing Medicare-Medicaid hospital cost control regulations. The action is seeking a preliminary injunction against regulations which

set limits on routine service costs and short term, non-federal hospitals.

AAMC said that the regulations failed to consider factors in hospital cost measurement that the Congress wrote into the law; namely, the scope of services offered, the quality and intensity of care, and hospitals educational programs. As a result, many hospitals' daily cost will soar far beyond the amounts allowed, AAMC says.

HEW's reimbursement schedule for these routine daily costs groups hospitals according to their urban or nonurban location, area per-capita income, and bed number. AAMC President, John A. D. Cooper, MD, said, "if these new regulations are allowed to stand, Medicare patients could lose up to \$68 million worth of hospital services next year." He went on to point out that Medicaid charges would also be affected since they are tied directly to those of Medicare.

"The new ceilings for payments will work a tremendous hardship on you as hospitals," the President said. "More importantly, they will, for the first time since Medicare began, place many Medicare patients in jeopardy of having to pay for a portion of their hospital costs." □

Medical Assistants' Seminars Scheduled

A series of seminars for the persons that work in physicians' offices have now been scheduled by the Oklahoma Chapter of the American Association of Medical Assistants, Inc., State of Oklahoma, Inc. Working with the Continuing Education Department of the University of Oklahoma, medical assistants have set up a series of six day-long programs to be spread over the next eight months.

Each of the six sessions will focus on a particular area of a medical assistants responsibility. It is hoped that the series will assist Oklahoma physicians with the problem of staff training.

Each of the sessions will be held in Kellogg Center on the Oklahoma University Norman Campus. Registration fee, which includes course materials and lunch, will be \$15 per

session for members and \$18 for non-members or a person can pre-register for all six programs for \$75 for members and \$90 for non-members. For members of AAMA, continuing education units will be awarded to all participants for attendance in each session.

Each of the six scheduled sessions will start at 9:00 in the morning and be completed by about 3:00 in the afternoon. The first will be on September 6th. The morning program will be entitled "Expectations of the Physician" and will feature V. Michael Barkett, MD, Oklahoma City. The afternoon session will deal with telephone techniques and oral communications with representatives from Southwestern Bell Telephone and a panel of medical assistants contributing to the program.

The second session is scheduled for October 18th. The morning portion will be devoted to written communications, bookkeeping and indexing in filing. Doctor Laura Blair, Oklahoma University, will be responsible for the morning presentation. The afternoon program will deal with United States mail service, or "How To Realize Maximum Benefits from the Public Mail System."

The third session is scheduled for December 6th and will cover examining room techniques, sterilization and care of equipment. The afternoon will be devoted to medical emergencies and injections and medications.

The first session of the new year is set for January 17th, 1976. The entire program will be devoted to study of the Standard Office Procedure Manual and will include actual exercises in devising a Procedural Manual for each office represented. A *Special Physicians Management Journal* is being prepared for this session. The price of the manual will be approximately \$30 and it will be divided into 12 subdivisions.

The session scheduled for February 21st will deal with laboratory procedures, immunology, x-ray and physiotherapy.

The last scheduled session will be on April 10th and subjects will include medical ethics, law and economics, medical records and credit information and collections.

Persons wishing to attend the meetings should direct their reservations to Mr. Floyd Taylor, Education and Certification Committee, AAMA, Incorporated, State of Oklahoma, Inc., 4200 W. Memorial Road, Oklahoma City, Oklahoma 73120. Reservations may also be made with Mr. Taylor's office at the Kellogg Center in Norman. □

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Hypertension Subject Of Three-Day Seminar

"A New Look at the Hypertensions" will be the subject of an October 2nd-4th seminar being sponsored by the University of Oklahoma Health Sciences Center and the American College of Physicians.

The program is being directed by Edward D. Frohlich, MD and is scheduled for the Skirvin Plaza Hotel. While most courses on hypertension have been directed toward establishment of uniform community health programs for the detection and evaluation of a hypertensive patient, this three-day program has been designed for the practicing internist and family physician to update their concepts of the broad considerations that underlie the multiplicity of problems that afflict patients with hypertension.

One half-day each will be devoted to the endocrine, renal and cardiovascular areas with additional half-days each devoted to under-

standing of the new diagnostic techniques and therapeutic advances.

Guest faculty for the course includes Norman N. Kaplan, MD, Professor of Internal Medicine at the University of Texas Southwestern Medical School in Dallas; John H. Laragh, MD, Master Professor of Medicine and Director of Hypertension Center and Cardiovascular Center at the New York Hospital-Cornell Medical Center; and Morton H. Maxwell, MD, Director of Hypertension Services at the Cedars-Sinai Medical Center and Clinical Professor of Medicine at UCLA School of Medicine.

In addition to the guest faculty, some 21 members of the University of Oklahoma faculty will serve on the program.

Registration is limited to 150 people maximum. Registration fee is \$150 for members or fellows of the American College of Physicians; \$175 for non-members; \$60 for ACP associates; other residents and fellows are \$120; and students are \$50.

Registration and request for information should be directed to Registrar, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104. □



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Patient Referral System Expanded

An expanded patient referral system, designed to facilitate referrals from physicians around the state, is now in operation at The University Hospital and Clinics.

Announcement of the operation of the expanded referral system was made by Don H. O'Donoghue, MD, Oklahoma City physician and Chairman of the hospital's Board of Trustees. "This broadened program, combined with the modern private facilities of the Everett Building and the reopening this month of three completely remodeled nursing units, provides us with the elements to respond quickly to physician referrals from around the state and to better deliver high quality, comprehensive health services to patients from all walks of life," Doctor O'Donoghue said.

"An important element of the expanded referral system is a new toll-free telephone line now available to physicians for their referrals," G. Rainey Williams, MD, Associate Chief of Staff and a member of the Task Force for Implementation of the Referral System, explained. "This referral number, 1-800-522-4264, is available to physicians throughout the state," Doctor Williams continued. He also noted that physicians in the Oklahoma City metropolitan area can call the local number, 271-4900.

"This new mechanism for referrals is intended to make it possible for any physician to discuss medical problems or to refer patients with a minimum expenditure of time and effort," Doctor Williams added.

Another important element of this expanded referral program is the hospital's newly acquired emergency vehicle which contains life support equipment. "This vehicle is designed as a life-supporting vehicle for facilitating referral of the critically ill," Doctor Williams noted. "It will not compete with any commercial ambulance service," he emphasized.

"The vehicle will be utilized in three types of situations calling for life-support equipment," Doctor Williams said. These three situations include (1) transferring critically ill patients from the MAST helicopter at the Governor's Helipad to University Hospital; (2) admission to University Hospital of critically ill or injured patients who require the use of equipment in this emergency vehicle when no comparable vehicle is available and (3) pick-up and delivery of University Hospital patients who require specialized services at other metropoli-

tan hospitals which are not available at University Hospital, such as the EMI scanner or some types of renal dialysis.

The vehicle will be staffed with registered Emergency Medical Technicians 24 hours a day plus other nursing and allied health personnel as indicated by the patient's condition and the judgment of the University Hospital clinical staff member who is accepting the patient. A basic pick-up charge will be assessed for use of the vehicle, as well as a mileage charge outside the metropolitan Oklahoma City area.

Doctor Williams noted that physicians across the state will be receiving next month a newly developed Referral Guide containing information about each of the hospital's service areas, referral and admitting procedures. This guide also includes information for patients and visitors, maps of the area and of the hospital, and written directions on how to reach the hospital from major highways which the physicians can reproduce and give to their patients being referred to University Hospital.

"This streamlined referral system, which was partially funded under a grant from the Oklahoma Regional Medical Program, is designed to improve procedures for making the tertiary patient care resources and services of this hospital more available to all Oklahomans, particularly those in underserved rural areas," Doctor Williams emphasized. "Much work and effort has been put into improving communication procedures and establishing the referral telephone lines. We hope this is evidenced in our ability to better meet the needs of referring physicians." □

DEATH

RICHARD B. LINCOLN, MD
1919-1975

Richard B. Lincoln, MD, 56, Oklahoma City psychiatrist and neurologist, died July 10th, 1975. Born in Muskogee, Oklahoma, Doctor Lincoln moved to Oklahoma City in 1940. He was graduated from the University of Oklahoma College of Medicine in 1946. Following residency training in Oklahoma City and Chicago, he established his practice in Oklahoma City in 1950.

Doctor Lincoln was a member of the Oklahoma City Clinical Society. □

Tulsa Site For AMA Regional Meeting

Tulsa has been selected as the site for a two-day AMA Regional Scientific Meeting next year.

For many years the American Medical Association has held two large scientific meetings each year, one in the spring and the second in the fall. The fall meeting is now being phased out and replaced by regional scientific meetings scattered throughout the United States.

The Tulsa meeting will be held Saturday and Sunday, January 17th and 18th. The program for the first day will include "Child in the Emergency Room" and "Cardiac Arrhythmias." The Sunday program will include "Dermatology for the Non-Dermatologist," "Management of the Critically Injured," and "Acid-Base Fluid and Electrolyte Balance."

Cardiopulmonary resuscitation will be presented both days.

The AMA's Department of Scientific Assembly is working with Doctor Ralph Richter, Director of Continuing Medical Education at the University of Oklahoma School of Medicine in Tulsa to plan the two-day program. As soon as the program is finalized, formal invitations and schedules will be printed for distribution to all physicians in this region of the United States. □

JCAH Sues HEW Over Survey Documents

The disclosure of survey documents provided to the Health, Education and Welfare Department by the Joint Commission on Accreditation of Hospitals has resulted in a lawsuit. The suit, filed in US District Court, calls for a permanent injunction to prevent further public disclosure of JCAH survey documents provided for the purpose of validation surveys conducted by HEW.

The Joint Commission filed the complaint May 30th against Caspar Weinberger as Secretary of the Department of Health, Education and Welfare.

Title XVIII of the Social Security Act provides that a hospital accredited by JCAH

"shall be deemed" in compliance with the conditions of participation for Medicare. In 1972 the law was amended to provide that the state agencies in agreement with HEW could conduct validation surveys of JCAH creditation findings on a random sample basis. JCAH was then to provide the Secretary of HEW "on a confidential basis" and with the hospitals' permission, its most current survey of those hospitals selected for the validation survey process.

On April 24th Secretary Weinberger released to the Consumer Commission on the Accreditation of Health Services, Inc., of New York, 105 of the JCAH accreditation letters and accompanying recommendations and comments.

In the lawsuit, JCAH maintains that its standards for accreditation of hospitals represent "optimal achievable standards" and that the criticism letters are designed to assist the hospital achiever optimum standards, not minimum standards.

At the same time JCAH was filing its lawsuit, it was informing the Secretary that the organization was immediately discontinuing the provision of hospital survey reports to the Bureau of Health Insurance pending a reestablishment of a basis of confidential handling of data thus supplied. □

Tulsa County Society Awards Educational Grants

The Scholarship Fund of Tulsa County Medical Society has announced a total of \$7,500 in educational assistance grants to eleven area medical and nursing students for the 1975-76 school year.

E. N. Lubin, MD, President, said the sum was a record annual distribution by the non-profit educational trust established in 1963 by the doctors' group.

Winners of the Doctor Anna Luvern Hays Memorial Scholarships of \$700 each are Danny A. Amrine, Titus D. Duncan, Bruce A. Kraemer, Michael A. Madden, from Tulsa, and Teresa M. Shavney, Sand Springs.

Amrine and Duncan are sophomores at the University of Oklahoma College of Medicine, and Shavney is a freshman at the same school. Kraemer is a freshman at Washington University School of Medicine, St. Louis, Missouri,

and Madden is a sophomore at Georgetown University School of Medicine, Washington, D.C. These awards are made possible by a bequest from the late Doctor Anna Luvern Hays, Tulsa pediatrician who died in 1965.

The Doctor Frank L. and Jessie O. Flack Scholarship of \$700 was given to Beverly N. Balfour, Tulsa, a freshman at the University of Oklahoma College of Medicine. The award was created by Mrs. Flack in memory of her husband, Doctor Frank L. Flack, Tulsa surgeon who died in 1963. It was first given two years ago.

The second annual award of the Glenda Ann Cale Memorial Scholarship of \$700 again went to Susan M. O'Brien, Tulsa, a sophomore at the University of Oklahoma College of Medicine. This scholarship was established last year in memory of a 23-year old Southwestern Bell Telephone Company employee found murdered in late 1972. It utilizes an unclaimed reward fund raised by Tulsa physicians and other friends of Miss Cale.

The Doctor O. C. Armstrong Scholarship of \$700, created by the retired Tulsa physician, was given to Sharon M. Henthorn, Tulsa, a senior at the University of Oklahoma College of Medicine, Tulsa. She is the first student of the new Tulsa medical college to receive an award.

The Doctor Goerge H. Miller Memorial Scholarship was received by Douglas G. Cox, Tulsa, an O.U. College of Medicine sophomore. It was made possible by gifts from the family and friends of the late Doctor George H. Miller, Tulsa surgeon, who died last January 30. The amount is \$700.

Aletha C. Oglesby, Tulsa, was recipient of the \$700 annual scholarship given by the Woman's Auxiliary to Tulsa County Medical Society. She is a sophomore at the University of Oklahoma College of Medicine.

Winner of the Doctor Maxwell A. Johnson Memorial Scholarship of \$500 was Gerald H. Milligan, Tulsa, a senior at Harris College of Nursing, Tulsa Christian University, Fort Worth, Texas. The award was created in memory of the Tulsa urologist and medical leader who died in 1971.

Amrine, Duncan, O'Brien, Oglesby and Milligan are previous recipients of awards from the Scholarship Fund of Tulsa County Medical Society.

The annual educational assistance program is designed to stimulate interest in careers in medicine and allied health sciences. □

Pharmacists' Convention Adopts Drug Resolutions

During its June meeting the Oklahoma Pharmaceutical Association, made up of pharmacists from throughout the state, adopted a number of resolutions dealing with prescriptions for drugs.

In one action the pharmacists again restated their intention to discourage and prevent the advertising of prescription drugs to the general public.

Three resolutions of particular importance to prescribing physicians were adopted. The resolutions outlined problems that the pharmacists encounter when a prescription is not properly prepared. The pharmacists encourage all practitioners to indicate on the prescription whether or not it should be refilled, thus eliminating unnecessary phone calls.

Another problem area is that of prescriber identification on a hospital prescription blank. Frequently pharmacists are presented with a prescription on a hospital blank that does not have the physician's name imprinted on it. The problem is compounded when the prescription is signed by an intern or resident unknown to the pharmacist.

The pharmacists also passed a resolution to remind all physicians that the pharmacists must file controlled substances prescriptions in a separate file. A problem is presented whenever a physician writes multiple prescriptions on the same blank and only some of them are for controlled substances.

Resolutions were adopted by the Oklahoma Pharmaceutical Association during its annual meeting June 6th-8th. □

Remember These Dates -

MAY 5th, 6th, 7th, 8th, 1976

Oklahoma Medical Summit '76

A combined meeting of the Oklahoma State Medical Association, the Oklahoma City Clinical Society and the Oklahoma Academy of Family Physicians.

Health Service Area Configuration Confirmed

Governor David Boren's decision to designate the State of Oklahoma as one Health Service Area has apparently been upheld amidst speculation he might change his mind. Newspaper accounts indicated that at the request of Congressman James Jones, Tulsa, the Governor may reconsider his decision. Authorities in the Governor's office have stated that no change in the plan will be requested although regional DHEW officials suggested that the Governor reconsider. State HSA designations are to be published in the Federal Register on August 1st finalizing the first step in implementing the National Health Planning and Resources Development Act of 1974.

The comprehensive law has as its primary objective the planning, development and implementation of a national health policy that will provide equal access to quality health care. Several major health programs are being replaced by the new Act including the Hill-Burton and Regional Medical Programs. To accomplish legislative intent the Secretary of Health, Education and Welfare is to divide all states into Health Service Areas. Each area will organize Health System Agencies to carry out the area health plan.

Under the law Oklahoma could have been divided into four health service areas — a plan advocated by many state physicians. Each Health System Agency is autonomous and can enter directly into contracts with the federal government — a violation of state sovereignty felt those opposed to the multi-area approach.

Governor Boren attempted to accommodate some of the philosophy of both. With the plan submitted to Secretary Weinberger, Governor Boren wrote "I recommend that the entire State of Oklahoma be designated as one health service area because this configuration is the most appropriate area for health planning and resources development purposes in our State. My recommendation of a single area is contingent upon acceptance of my recommendation for the creation of regional units, six in number, which would each be represented on the governing board of the HSA. This will provide general coordination while preserving local input." Though opting for the

single area plan the Governor recognized the strengths of the multi-area designation. "A multi-area configuration of four areas with two rural and two metropolitan was advocated as the best option to achieve the greatest degree of local control, participation and input with a consequent decentralization of power and recognition of the problems of different areas of the State," said the Governor's letter. However, in continuing to develop his case for the single Health Service Area the Governor's letter stated "the basic thrust of the law is to have a geographic area appropriate for the effective planning and development of health services. Since the major patient flow and referral patterns in our state are internal and directed toward the two metropolitan centers of our state, a statewide health service area already exists and such a designation would ensure the maximum degree of development of our health care delivery system into an integrated and coordinated network of primary, secondary and tertiary services. The metropolitan centers have a responsibility to work in conjunction with the rural areas to see that services are provided to the people where they are most needed. Our health problems in Oklahoma are statewide in scope and should be approached as such.

Acceptance of the plan apparently clears the way for formation of the board and organizational entity that will contract with DHEW to perform the functions required by the law. Consistent with other recent health laws, the governing board must be representative of the general public, only forty percent will be health care providers, the definition of which includes physicians, dentists, nurses, hospitals, nursing homes, health care and allied health professionals.

The Board of the HSA has broad responsibilities:

"(1) improving the health of residents of a health service area,

"(2) increasing accessibility (including overcoming geographic, architectural, and transportation barriers), acceptability, continuity and quality of the health services provided them,

"(3) restraining increases in the cost of providing them health services, and

"(4) preventing unnecessary duplication of health resources . . ."

It is anticipated that the HSA Board will be appointed, staff hired and funded by January, 1976. □

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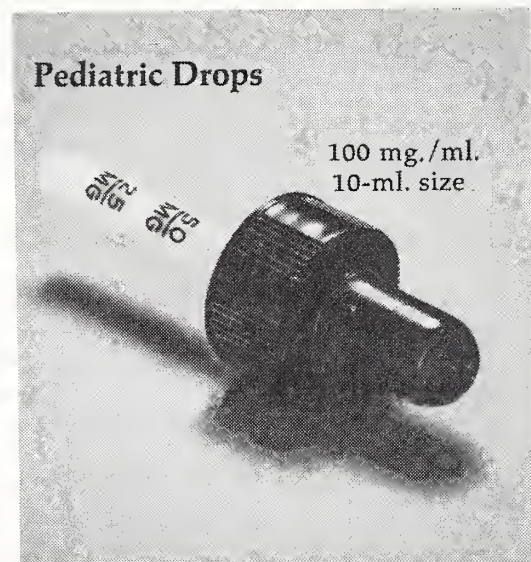
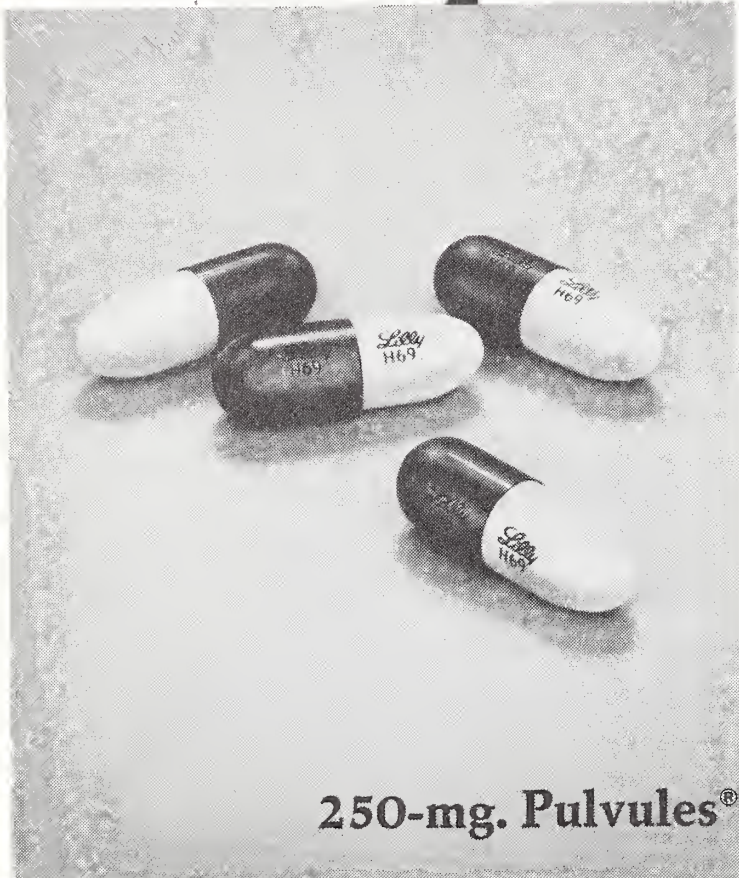
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"The Crime of Psychiatric Punishment in the Soviet Union"

Students of the Nazi holocaust were under the impression that the Nazis had exhausted the range of physical and mental torture and cruelty. It was left to the Soviet penal system to add another refinement to the never-ending range of human brutality. The additional feature concerns the incarceration of dissenters in mental institutions. This novel approach in the handling of non-conforming intellectuals and political activists started late in 1968 and was publicized by the famous academician Andrei Sakharov in 1973. But a recent issue of the respected British Journal, *Nature* (November 22, 1974) gives a more detailed picture of this abuse of psychiatry. It contains an eye-witness account by Victor Fainberg, who after long retention was allowed to emigrate to Israel and — at a stop-over in London — provided the editors with massive background material on this shattering criminological approach. The psychiatrists in these penal institutions are officers of the Soviet secret police and wear uniforms that indicate their military rank and status. Ordinary criminals serve as male nurses, tormenting the patients and stealing their food parcels. The medical care for somatic ailments is completely insufficient and results in high mortality after acute surgery.

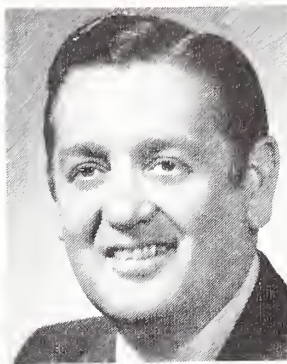
How does a dissident reach such an institution? Mr. Fainberg was a member of a human rights group in Leningrad that was in contact with the Moscow group of Sakharov. The criteria of selection for psychiatric "treatment" are arbitrary, the alternative being a sentence in a Soviet labor camp. Fainberg suggests that the psychiatric approach as an alternative punishment is chosen if the questionable offense, such as contempt of court, carries a relatively mild sentence. On the other hand, the culprit selected for compulsory psychiatric treatment may be retained for an indefinite period. The diagnosis in general is schizophrenia. If by chance conflicting

psychiatric opinion is voiced in favor of the defendant, a second psychiatric consultation is sought that generally conforms with the intentions of the system. In the penal mental hospital the dissidents are isolated from other patients and the general handling of the inmates is harsh. "Treatment" consists essentially of massive doses of chlorpromazin far in excess of conventional therapeutic dosages. Other tormenting methods are also used. A chemist by the name of Chinov was subjected to 30 insulin shocks and additional electro-convulsive therapy. If the treatment is refused by the patient, he is subjected to severe physical manhandling by the orderlies. While the pattern of treatments varies in different hospitals, it seems most severe and cruel in the outlying districts, sheltered from the public eye and particularly from the foreign press. According to Fainberg this handling of dissenters is not a sincere, although misguided, therapeutic attempt to bring maladjusted and disturbed persons back to the social norm, but a deliberate and cynical exploitation of professional skill for purposes of isolation and punishment.

What can American and Western European psychiatry do to prevent such appalling abuses of their field? Fainberg himself gives us a hint by stating that the referral of a certain intellectual to a forensic psychiatric institute was retracted, since at that time a meeting of the World Congress of Psychiatrists was taking place in Mexico and the Soviets feared possible repercussions of world psychiatry. This is confirmed in another field, the arts, where the world renowned cellist Rostropovich, who emigrated to the West with his wife, a famous opera star, stated that the reaction of the Western World is closely watched in the Soviet Union and may influence their actions. This makes it incumbent on Western psychiatrists, again and again to call attention to the described criminal abuses of their field in the Soviet Union and to voice determined protests at their conventions and in their literature.

Ernest Lachman, MD

The National Cancer Act of 1971 clearly established the conquest of cancer as a National Priority. In 1972, our Oklahoma Governor established the "Governor's Committee to Combat Cancer," which at this time has a membership of twenty-eight. There are twenty physicians and eight laymen on the committee. This committee has been very capably chaired by Mark Johnson, MD, of Oklahoma City. The duties of the committee include developmental work needed to fully exploit existing knowledge about cancer prevention, detection, diagnosis, treatment and rehabilitation.



The exact reason that our Governor had in mind when the committee was formed is unknown by the writer. This fact is of little or no importance. The fact is, that a very worth while committee was started, and it is rendering a great service to at least part of the people of Oklahoma. It is anticipated that an even greater service will be rendered to Oklahoma citizens in the future. Such a program to combat cancer is long overdue. This program is unique in that it is one of the first like it in the country.

As always, progress is painful and it takes work and determination on the part of the committee and anyone who assists them. The committee has focused its attention on the more common type cancers such as cancer of the colon, breast, cervix, uterus, and prostate. An effort is being made to detect the high cancer risk individuals. Such information concerning the high risk patient is not only of great value to the practicing physician, but also to his patient as well. The physician will be provided with information needed to prescribe appropriate prevention, detection, and treatment. It is felt that there is good reason to expect a significant impact on the cancer survival rate. The first objective of the committee has been to develop a practical method of identifying individuals who are unusual high risks for cancer.

The committee made the decision to use one area of Oklahoma as a test area. Pontotoc County was the area to be used for the first study. Seven thousand, eight hundred and forty-two questionnaires were sent out to the residents of Ada, Oklahoma, to individuals who had reached their 30th birthdays. Of this group, 2,787 responded. There were 7,093 ques-

tionnaires sent out to the rural Pontotoc county residents who had reached their 30th birthday. Seven hundred and three responded, making a total of 3,490 respondents, or 23% of the entire group who received questionnaires. It is the feeling of the committee that this represents a satisfactory response during the early stages of this program.

Since that time other organizations have been called in for their assistance in the operation of this program. The Oklahoma State Health Department, the Oklahoma State Medical Association, The Oklahoma Division of the American Cancer Society, and the Oklahoma Health Sciences Center now play an important roll in the operation of this program. The Governor's office has continued to lead the way in the overall committee work. The committee has received financing from both state and federal agencies. The overall name of the committee has now been changed to the State Cancer Hospital Network Program.

The participation of individual physicians is vital for the success of the program. It is imperative that the Cancer Hospital Network Program remains as a committee of the state. None of the participating organizations should be allowed to take over this program. It is vital for the success of this program to remain as it is.

It is estimated that the total incidents of cancer in Oklahoma in 1975 will be 9,450 cases. Of this group, it is further estimated that 4,700 will die from their cancer. From these figures, it is very clear that we need to improve the survival rate from this dreaded disease. It is also clear that this cancer detection program needs to be broadened to cover the entire state. At a recent meeting of the Cancer Hospital Network Program, in Shawnee, Oklahoma, many new directions in which to go were discussed. The Governor's Cancer Committee is now being assisted by hospital administrators, radiologists, chiefs of staffs of various hospitals, and many other individual physicians. It has been pointed out by the Governor, and by the committee, that each individual cancer patient should receive the best individualized care that is available today. This care should be rendered in an area nearest the patient's home where the proper treatment is available. I sincerely request once again, a unified effort for this important purpose.

Arnold G. Nelson, M.D.

Metabolic and Hemodynamic Effects of Diphenylhydantoin

S. S. SANBAR, MD, PhD

Diphenylhydantoin (Dilantin), anti-convulsant and anti-arrhythmic drug, induces hyperglycemia, increases plasma free fatty acids, and increases carotid blood flow, despite transient hypotension and left ventricular failure.

INTRODUCTION

DIPHENYLHYDANTOIN (DPH, DILANTIN) is a well-known anti-convulsant drug^{1,2} which has been shown recently to be effective in the management of some cardiac arrhythmias.³⁻⁶ The daily dose of DPH administered to human subjects with cardiac arrhythmias has ranged between 5 and 15 mg per kg body weight.⁴⁻⁹ In dogs and pigs, experimentally-induced cardiac arrhythmias have been treated with 5 to 50 mg/kg per day.¹⁰⁻¹⁶

Recently, it has become apparent that large doses of Dilantin influence carbohydrate and

lipid metabolism. In 1965, Belton and co-workers¹⁷ observed that intraperitoneal injection of DPH (70 mg/kg) in rabbits elicited a substantial increase in blood glucose concentration. In the following year, Klein¹⁸ reported the first case of DPH-induced hyperglycemia. The case was that of a 22-month-old infant who developed marked hyperglycemia, glycosuria, convulsions and coma following the inadvertent oral administration of approximately 70 to 80 mg/kg over a period of 24 hours; the infant recovered within one week. In 1967, Dahl¹⁹ noted the development of hyperglycemia and glycosuria in an adult, epileptic, nondiabetic subject after increasing the oral dose of DPH from 300 to 700 mg per day; carbohydrate metabolism normalized following reduction of the dose of DPH to 200 mg daily. In 1969, Goldberg and Sanbar²⁰ reported two critically ill patients in whom the intravenous administration of DPH was associated with marked hyperglycemia and coma; both of them died. In 1970, Levin *et al*²¹ and Kizer *et al*²² independently reported that DPH inhibits insulin secretion in vitro. In 1973, Levin *et al*²³ showed that DPH inhibited arginine-induced insulin secretion in patients with mild oral glucose intolerance, thereby unmasking early defects of insulin secretion. Finally, in 1974, Stambaugh and Tucker²⁴ reported that DPH (600 mg daily) administration to five patients with symptomatic hypoglycemia, unresponsive

Work performed in parts at the Department of Internal Medicine, University of Michigan, Ann Arbor, Michigan, and at the US Army Medical and Nutrition Laboratory, Fitzsimons General Hospital, Denver, Colorado.

From the High Blood Pressure, Hyperlipidemia and Cardiovascular Clinic, 1509 North Rockwell, Oklahoma City, Oklahoma 73127.

to dietary management, produced both subjective and objective improvement in all cases.

With regard to the effect of DPH on lipid metabolism, Chung and coworkers^{25,26} reported that intraperitoneal injection of DPH (25 mg daily) for 10 to 12 days in rats produced significant reductions in the dermal content of glycerides and phospholipids, but not cholesterol. These authors reported also that the glyceride, but not phospholipid or cholesterol, content of rat liver and aortic tissue diminished significantly after DPH. In 1965, Chung²⁷ observed in rats that DPH (75 mg/kg) significantly increased the concentration of plasma free fatty acid (FFA) in both fed and fasted states, and that administration of DPH in combination with epinephrine produced a synergistic effect in raising plasma FFA concentration.

The purpose of this study has been to compare in dogs the acute effects of large intravenous doses of DPH on cardiovascular hemodynamics and on the concentrations of plasma glucose, FFA, cholesterol, triglyceride and insulin, and glucose turnover. Results of this study have been reported partly in abstract form.²⁸

MATERIALS AND METHODS

Animals

The experiments were carried out on 20 male and female mongrel dogs weighing 14 to 21 kg. After an overnight fast, the dogs were anesthetized with pentobarbital sodium (initial intravenous dose 30 mg/kg) and were kept at the level of surgical anesthesia throughout the procedures. Each dog served as its own control in all experiments.

A 1960 graduate of the American University of Beirut, Lebanon, S. S. Sanbar, MD, PhD, limits his practice to his specialty of cardiology and internal medicine. He is Clinical Assistant Professor at the University of Oklahoma Health Sciences Center. His medical affiliations include the American Heart Association, the American Diabetes Association, the American Federation for Clinical Research, the Cardiac Society and the Osler Society.

Hemodynamic Studies

Hemodynamic studies were carried out on four dogs. An indwelling catheter was placed in the cephalic vein for intravenous injections. A polyethylene tube was inserted in the left femoral artery, and under fluoroscopic guidance, cardiac catheters were placed in the left ventricle via the right brachial artery and in the main pulmonary artery via the left femoral vein, for measurements of pressures. Statham pressure transducers were used. Electromagnetic flow probes (Micron Instrument) were placed in the right femoral and right common carotid arteries. Pressures, the first derivative of left ventricular pressure curve (dP/dt) and blood flow were recorded simultaneously using an Electronics for Medicine, Inc, recorder. Following the operative procedures, each dog was allowed to stabilize for at least 20 minutes prior to recording the control values. Subsequently, a single dose of DPH (25 mg/kg) was injected intravenously over a period of one-half to one minute.

Metabolic Studies

A medium size catheter (Intracath, C. R. Bard, Inc., Murray Hill, N.J.) was inserted in the cephalic vein for intravenous injections and a polyethylene tube in the femoral artery for blood pressure measurement and repeated blood sampling. After a control period of at least 30 minutes, three dogs received intravenously DPH diluent (1 ml/kg), three dogs received a single dose of DPH (25 mg/kg), four dogs received DPH (25 mg/kg) intravenously after having received DPH (25 mg/kg) intraperitoneally 24 hours previously, three dogs received DPH (15 mg/kg) as a single dose, and finally three dogs received five injections of DPH (5 mg/kg) at 30-minute intervals. Each dose of the drug was injected slowly over a period of two to four minutes.

In the group of four dogs, two single, intravenous injections of 20 μ C of high specific activity glucose-U-C¹⁴ (Nuclear-Chicago) were administered, the first 60 minutes before and the second 30 minutes after Dilantin administration. Fourteen arterial blood samples, 8 ml each, were obtained throughout the 2½-hour procedure for determination of specific activity of plasma glucose (see below). The rates of glucose appearance into and disappearance from the circulation were calcu-

lated as described by others.^{29, 30} Glucose turnover was also determined in the three dogs which received 15 mg/kg of Dilantin. These dogs received intravenously a priming dose of 15 μ C of glucose-U-C¹⁴ followed by a constant infusion of 0.191 μ C (in 0.382 ml saline solution) per minute over a period of 2½ hours, using a standard infusion pump (Harvard Apparatus Co, Dover, Mass.). DPH was injected one hour after starting the infusion of labeled glucose. Thirteen arterial blood samples were obtained throughout the procedure for analysis of specific activity of plasma glucose. Calculation of rates of plasma glucose appearance and disappearance were carried out according to the formulas used by Steele.³¹

Blood samples were mixed with heparin and placed in an ice-water bath. Plasma was separated within half an hour of collection. A portion of the plasma was stored at minus 15° C for future lipid analyses. In the experiments where labeled glucose was used, one milliliter of the plasma was immediately precipitated with zinc sulfate and barium hydroxide.³² After standing for 15 minutes the mixture was centrifuged and glucose was separated from the supernatant by column chromatography using an ion-exchange resin, Amberlite IRA-410.³³ The eluate was analyzed for glucose content³² by a modified Somogyi method as well as radioactivity, using a liquid scintillation spectrometer (Nuclear-Chicago). The remainder of the plasma was analyzed subsequently for free fatty acids,³⁴ cholesterol,³⁵ triglyceride³⁶ and insulin by a radioimmunoassay.*

RESULTS

Hemodynamic parameters

Intravenous administration of DPH diluent (1 ml/kg) in three dogs did not alter significantly either the systolic blood pressure or heart rate. (Fig. 1, left upper) On the other hand, injection over approximately four minutes of DPH (25 mg/kg) in three other dogs significantly ($p < .05$) diminished systolic blood pressure with a maximal decrease of 23 mm Hg below control values occurring 40 minutes after injection and a return to control values occurring after 120 minutes (Fig 1, right upper); the heart rate was decreased slightly but not significantly after DPH injection.

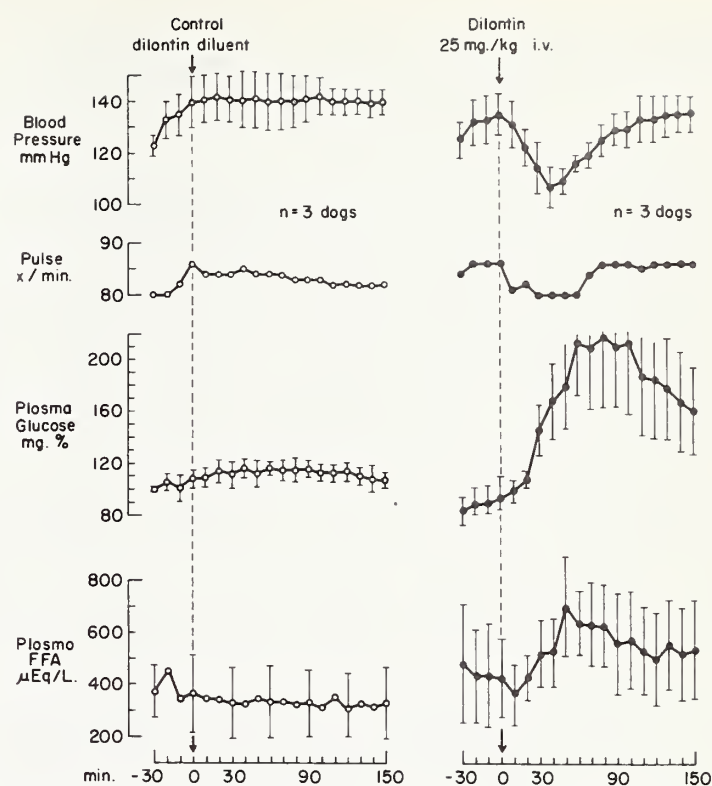


Fig 1: Changes in arterial systolic pressure, heart rate and plasma glucose and FFA following intravenous administration of Dilantin (DPH) diluent (left half) and 25 Dilantin 25 mg/kg (right half) in three anesthetized dogs. Injection time was approximately four minutes. In the significant figures circles represent the mean values for the groups, whereas the vertical lines represent the standard error of the mean (SEM).

Intravenous administration of five injections of DPH (5 mg/kg) at intervals of 30 minutes produced in three dogs no significant alterations in either systolic pressure or heart rate (Fig 2). Each dose was delivered over approximately two minutes.

The hemodynamic effects of DPH (25 mg/kg) injected intravenously over a period of one-half to one minute, are all shown in Figs 3 and 4. Femoral arterial systolic and diastolic blood pressure fell precipitously during the first one-half minute after injection of DPH and gradually returned toward control values; mean femoral arterial blood pressure decreased from 140 to a minimum of 80 mm Hg. Left ventricular end diastolic pressure increased from five to a maximum of 13 mm Hg after one minute of injection, with a return to control values after 10 to 15 minutes. The peak of the first derivative of left ventricular pressure curve (dP/dt) decreased by 47% below control during the first minutes after DPH, with a return to control values after 15 minutes. Pulmonary artery pressure increased from 21/11 to a maximum of 33/19 mm Hg. five minutes after injection, with a return to control values 15 minutes after injection. Finally, femoral ar-

*Kindly performed by Doctor John C. Floyd, Department of Internal Medicine, University of Michigan, Ann Arbor, Michigan.

Diphenylhydantoin / SANBAR

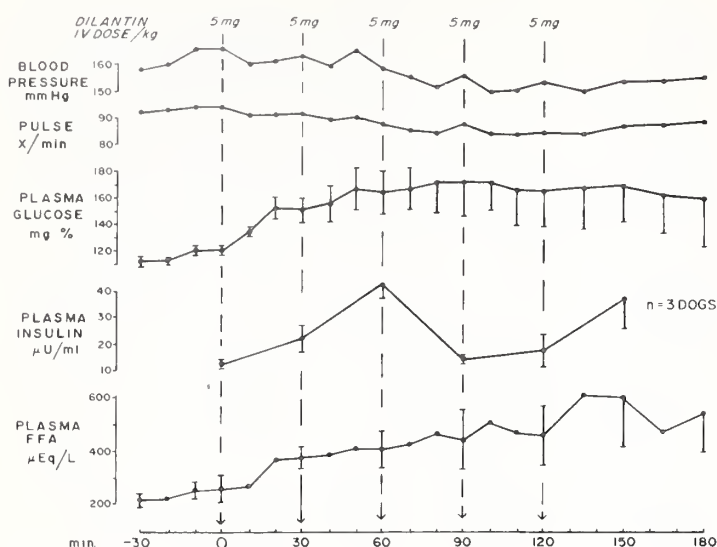


Fig 2: Changes in arterial systolic pressure, heart rate and concentrations of plasma glucose, insulin and FFA following five injections of Dilantin (DPH) 5 mg/kg injected at intervals of 30 minutes in three anesthetized dogs. Injection time was approximately two minutes per injection.

tery blood flow decreased by 40% during the first one-half minute after injection, but despite maintenance of hypotension, it returned to control level after five minutes. Carotid arterial blood flow increased by 39% one-half minute after injection with a return to control levels after 10 minutes.

Metabolic studies

Intravenous injection of DPH diluent (1 ml/kg) in three dogs produced no significant alterations in either plasma glucose or FFA concentrations. (Fig 1, left lower) On the other hand, injection of DPH (25 mg/kg) in three other dogs produced significant increments in plasma glucose and FFA concentrations with peak values occurring around 60 and 50 minutes, respectively; the mean values were still elevated at the end of the procedure. However, in these and subsequent experiments, the response of plasma glucose and FFA to DPH varied greatly from dog to dog.

Figure 2 depicts in three dogs the effects of five intravenous injections of DPH (5 mg/kg) at 30-minute intervals. Concentrations of plasma glucose, insulin and FFA were increased after the first injection of DPH. Plasma glucose reached a peak of about 40 mg per cent above control levels following the third dose of DPH, and subsequent injections produced no further increment in plasma glucose. Plasma insulin concentration showed a biphasic response. It

increased after the first two injections, then returned toward control levels; it increased again 30 minutes after the fifth injection of DPH. Plasma FFA concentration showed a gradual increase, reaching a peak of about 300 μ Eq per liter after the fifth injection of the drug.

Figure 5 shows the metabolic effects of intravenous injection of DPH (25 mg/kg) administered about 24 hours after a similar dose was injected intraperitoneally. Both plasma glucose and FFA concentration increased significantly after the intravenous dose, although the increment in plasma glucose was less marked than in the group of dogs which received only a single large dose of the drug. (Fig 1) It is also noted that the rate of fall of glucose specific activity in plasma did not change following DPH administration, despite the increase in plasma glucose concentration. The calculated rate of glucose appearance (R_a) into plasma increased by about 10% above control levels, while the rate of disappearance (R_d) of plasma glucose (tissue uptake) decreased by the same amount; control values for R_a and R_d were similar, being 3.9 mg glucose per mg per minute. Finally, plasma triglyceride and cholesterol concentrations did not change significantly during the procedure.

Intravenous administration of DPH (15 mg/kg) in three dogs produced peak increments in plasma glucose varying between 20 and 62 mg per cent above control levels. (Table I) Using the technique of a priming injection followed by a continuous infusion of glucose- $U-C^{14}$, rate of glucose appearance increased immediately after Dilantin injection, while rate of glucose disappearance did not change despite the increase in plasma glucose concentration, indicating a relative inhibition of glucose utilization.

DISCUSSION

In healthy, anesthetized dogs, intravenous administration of large doses of DPH produces transient hypotension, increased left ventricular end-diastolic and pulmonary artery pressures, decreased dP/dt and femoral artery blood flow, and increased common carotid artery blood flow. The changes in pulmonary artery pressure and carotid blood flow have not been reported previously. Mercer and Osborne⁵ have adequately reviewed the cardiovascular influences of DPH both in animals and in human beings. Intravenous administration of DPH both clinically and experimentally is

Table I

Changes in Plasma Glucose Concentration and Rates of Glucose Appearance and Disappearance Following Intravenous Injection of DPH (15 mg/kg) in three Anesthetized Dogs

Determination	Dog No.	Before Injection			After DPH					
		-20'	-10'	0'	15'	30'	45'	60'	75'	90'
Glucose Concentration	1	91	94	94	106	110	112	116	112	112
	2	112	112	121	149	140	144	145	149	147
	3	119	119	116	148	181	162	140	127	130
	Mean ± SEM	107 8.4	108 7.4	110 8.3	134 14.2	143 20.6	139 14.6	134 8.9	129 10.7	129 10.1
Rate of Glucose Appearance	1	3.6	3.7	3.2	4.6	3.8	3.6	3.6	3.1	3.3
	2	3.5	3.8	4.6	5.3	3.3	4.0	4.0	3.9	3.5
	3	4.9	5.2	4.7	7.4	7.8	4.5	3.8	4.8	5.0
	Mean ± SEM	4.0 0.4	4.2 0.5	4.1 0.5	5.7 0.9	5.0 1.4	4.0 0.3	3.8 0.1	3.9 0.5	3.9 0.5
Rate of Glucose Disappearance	1	3.3	3.3	3.2	3.6	3.4	3.4	3.3	3.4	3.3
	2	3.5	3.8	3.4	3.0	4.0	3.6	3.9	3.5	3.7
	3	4.8	5.2	5.0	5.0	5.3	6.0	5.5	5.7	4.8
	Mean ± SEM	3.8 0.5	4.1 0.6	3.9 0.6	3.8 0.6	4.3 0.6	4.3 0.8	4.2 0.6	4.2 0.8	3.9 0.4

often accompanied by hypotension which is apparently caused by a combination of direct myocardial depression, with decrement in cardiac output, and peripheral vasodilatation.^{5,37} Our findings in dogs are in accord with these

earlier reports. Myocardial depression is evidenced by a rise in left ventricular end diastolic pressure and a fall in maximal dP/dt. In addition, the fact that femoral artery blood flow returned to normal despite hypotension indicates a diminution in peripheral vascular resistance. It is also noteworthy that blood flow in the common carotid increased immediately after DPH, despite the marked hypotension, suggesting a direct vasodilatory action of DPH on the branches of the carotid artery. It cannot be distinguished from these studies the separate effects on cerebral and extracerebral vessels, but if the femoral flow pattern can be considered as an indication of the extracerebral carotid flow pattern, the marked early vasodilatation must have occurred mainly in cerebral vessels. Of interest, coronary blood flow also increases after DPH.³⁸ With regard to pulmonary artery pressure, Conn and co-workers³⁹ administered DPH (2.5 to 5.4 mg/kg) in the pulmonary artery of 12 human subjects during cardiac catheterization; no alteration in pulmonary artery pressure was noted. In our studies, larger systemic doses of DPH produced in dogs a transient increase in pulmonary artery pressure. It cannot be stated whether the latter is secondary to depressed

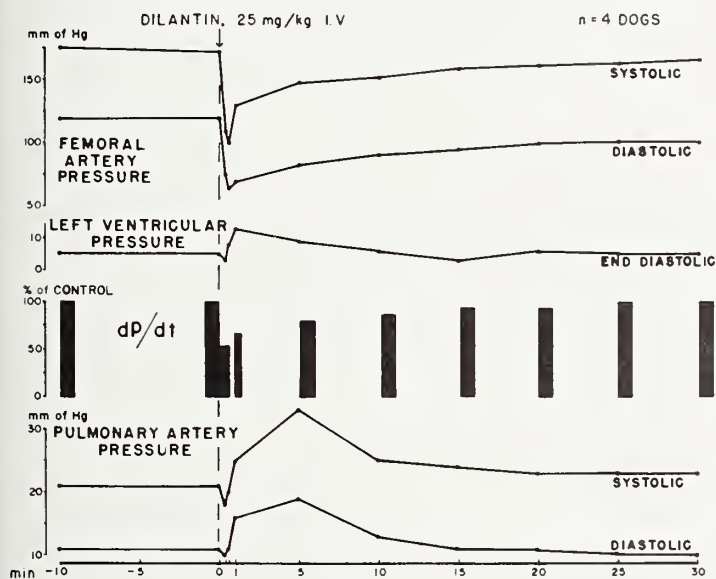


Fig 3: Changes in femoral artery systolic and diastolic blood pressure, left ventricular end diastolic pressure, first derivative of left ventricular pressure curve (dP/dt), and pulmonary artery systolic and diastolic blood pressure following injection of Dilantin (DPH) 25 mg/kg in four anesthetized dogs. Injection time ranged between one-half and one minute.

Diphenylhydantoin / SANBAR

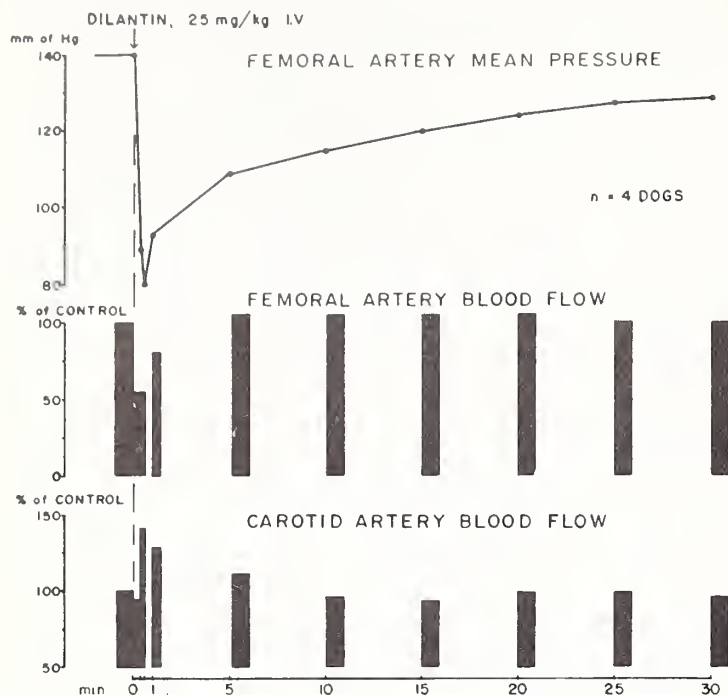


Fig 4: Changes in femoral artery mean blood pressure and blood flow, and main carotid artery blood flow in the same dogs depicted in Fig 3.

contractility of the left ventricle, increased pulmonary resistance or both.

Hypotension was most marked when DPH (25 mg/kg) was injected rapidly over a period of one-half to one minute. (Fig 3) When DPH (25 mg/kg) was administered over a period of approximately four minutes, hypotension was less marked. (Fig 1) And when the same dose of the drug was injected in five equal doses at 30-minute intervals, hypotension did not occur. (Fig 2) This emphasizes the importance of administering slowly the smallest dose required clinically in order to minimize the reduction in blood pressure and the depression of cardiac performance.

The metabolic studies in dogs show that DPH increases plasma glucose and FFA concentrations. These findings are in keeping with previous reports by several investigators.^{17-20,27} Using isotope dilution techniques, it has been determined that DPH hyperglycemia is associated with a slight increase in rate of appearance of glucose, which represents primarily hepatic glucose output.⁴⁰ Furthermore, despite a substantial hyperglycemia after DPH, the rate of disappearance or tissue uptake of glucose slightly decreased or remained unaltered. These data show, therefore, that both an increment in hepatic glucose output and an inhibition of tissue uptake of glucose contributed to the production of

DPH hyperglycemia. The effect of DPH on plasma insulin is in keeping with the reported data^{21,22} indicating inhibition of insulin release. Further investigations are needed to determine the mechanism by which DPH increases plasma FFA concentrations. The reduction in tissue content of glycerides in rabbits which received intraperitoneally 25 mg DPH daily for about 10 days suggests that lipid mobilization may play a role in raising plasma FFA. In contrast with the FFA, however, plasma triglyceride and cholesterol concentrations remained unaltered.

SUMMARY

The hemodynamic and metabolic effects of large intravenous injections of diphenylhydantoin (DPH) were investigated in 20 pento-barbital-anesthetized dogs. Injection of DPH diluent in three dogs did not alter blood pressure, heart rate, or plasma concentrations of glucose and free fatty acid (FFA). Injection of DPH (25 mg/kg) in four dogs promptly elicited the following maximal changes: fall in mean arterial blood pressure of 60 mm Hg; slight decrease in pulse; increase in left ventricular end diastolic pressure from a control of 5 to 13 mm Hg; 47% decrease in maximal dP/dt (first derivative of left ventricular pressure curve); increase in pulmonary artery pressure from 21/11 to 33/19 mm Hg; 40% decrease in femoral arterial blood flow; and 39% increase in carotid

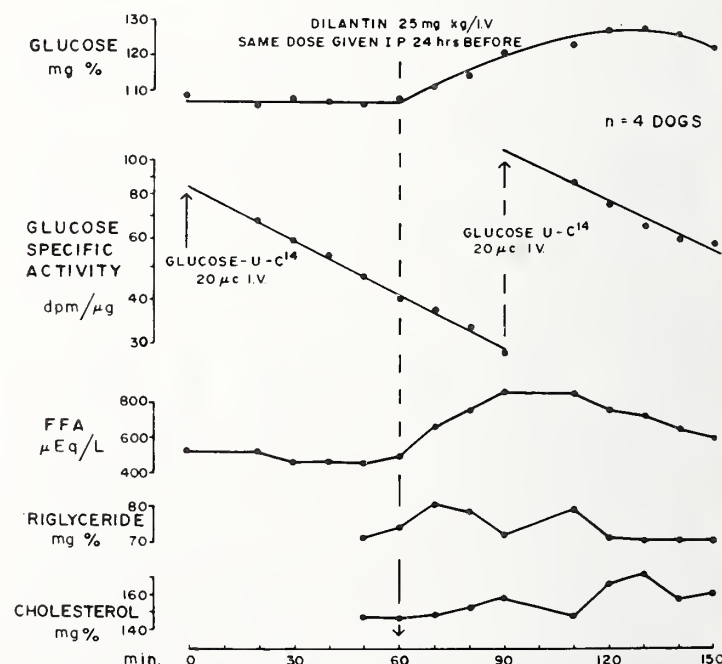


Fig 5: Changes in plasma glucose concentration and specific activity, and plasma FFA, triglyceride and cholesterol following two injections of Dilantin (DPH) 25 mg/kg at 24-hour intervals in four anesthetized dogs.

blood flow. All hemodynamic parameters except blood pressure returned to control values within 15 minutes. In 13 dogs, injections of DPH (5 to 25 mg/kg) produced substantial increments in plasma glucose and FFA levels which persisted over two hours; plasma cholesterol and triglyceride remained unaltered. Using glucose-U-C¹⁴, the rate of glucose appearance in plasma increased immediately after DPH, while the rate of glucose disappearance did not change. DPH hyperglycemia is thus due to enhanced glucose release and relative inhibition of glucose utilization.

The findings in dogs that DPH influences both hemodynamic and metabolic parameters are compared with similar published inferential data in humans.

ACKNOWLEDGEMENT

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Epidemiology of Bone Cancer In Oklahoma

JERE BRACEY, MS
NABIH R. ASAL, PhD

A consistently higher than US age adjusted death rates for bone cancer have been reported for Oklahoma males and females during a twenty-year period studied.

However, these rates appear on the decline, at least for the white population. Several counties with high mortality from bone cancer have been identified in Oklahoma.

The relationship between cancer of the bone and its suspected causative factors is not well defined due to a lack of definitive information about the incidence of the disease in the population. The increasing implementation of tumor registries in the future will afford the opportunity to remedy this situation through research. The extremely light coverage of this topic is evident on a research of the available literature. Fortunately there are a few well-designed studies with which contrasts and comparisons might be made.

In previous studies in England and Wales, Canada and the United States, perhaps the most striking factor was the similarity be-

tween the age distribution of the adolescent growth-spurt and bone cancer mortality.^{1-4,6,7} It is well known that osteosarcoma, a tumor which occurs mainly in the young, is generally associated with body sites of maximum growth. It therefore becomes extremely important to observe the changes in bone cancer mortality during the growth and development which occurs at puberty.³ It is also interesting to note that the incidence of cancer of bone is higher in males than in females. Osteosarcoma is the most common type of bone cancer, accounting for 58% of all confirmed cases.⁷ Sixty-one per cent of the tumors occurred in males.⁶ It has been noted however that at ages under 45 years the mortality is approximately equal in both sexes. At ages 45 years and over there is a sharp increase in the mortality among men but very little increase in women.⁴ The male excess in this group is largely accounted for by tumors of the ribs and shoulder-girdle.

The Mackenzie study found no significant difference in the geographical distribution of bone-tumor mortality.⁴ This is of interest since there is a popular hypothesis that bone cancer might be related to radioactivity in local food or water supplies. The literature hasn't provided convincing evidence to date that would indicate a definite correlation in practice even though it is well-accepted that excess radioactivity might predispose a subject to bone cancer. Epidemiological studies of low-level radium 226 exposure have been inconclusive.

In England and Wales during 1951-1953 it was estimated that the minimum annual mortality was 62.9 per 10,000,000 men and 38.9 per 10,000,000 women.⁴ Crude mortality rates

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(0 to 64 years) for 1961-1963 were lower than those estimated from the 1951-1953 data in England and Wales.¹ The male rate (0 to 64 years) was 53.2 per 10,000,000 per year compared with 62.9 per 10,000,000 in 1951-1953. Female mortality (0 to 64 years) also fell during the 10 years, from 38.9 to 33.4 per 10,000,000 per year.¹ In Canada it was found that the annual mortality rate was 63 per 10,000,000, 77 for males and 48 for females.⁶

Tumors of bones other than the limb bones account for about 30% of the total mortality.⁴ The mortality rises slowly from birth to ages 20-24 years and then remains fairly level for the following 20 years. In both sexes, however, the mortality at ages 20-24 years is slightly higher than that at ages 25 to 44 years. It is possible that tumors in this group also show a growth-spurt peak but it is much less marked than that found for tumors in limb bones.⁴ At older ages the mortality from tumors of bones other than limb bones rises sharply in men, but it remains constant in women until age 60-64 years, at which point there is a small increase.

So far there has been no evidence gathered which would implicate occupational hazards in the cause of bone cancer. It might be supposed that the studies on the effects of radiation would yield some inferences to occupational exposures but no research has been accomplished in this area to date.

METHOD OF PROCEDURE

Mortality data were obtained from death certificates filed in the Office of Vital Statistics, Oklahoma State Department of Health. Information from all resident death certificates filed between 1950 and 1970 indicating bone cancer as the underlying cause of death was transferred to IBM cards for tabulation. (Data from 1955 were missing.) The international classification of disease code revised in 1955 and 1965 was used for the purpose of separating bone cancer deaths from other cancer deaths. Utilization of both revisions was warranted since the Oklahoma State Department of Health adopted the 1965 revision during the 1969 and 1970 calendar years.

The data were analyzed according to sex, race, and year of death for the purpose of establishing secular trends. Annual death rates by sex for the total population as well as average annual death rates for the four five-year periods (1950-1954, 1956-1960, 1961-1965, 1966-1970) were also computed so that time

trends could be examined annually and for the four five-year time periods.

Bone cancer deaths and death rates by age, sex, and race for the 20-year period studied are presented so that the distribution of deaths by the age groups <5, 5-14, 15-24, 25-34, 35-44, 45-54, 55-64, 65-74, and 75+ could be shown for white males, white females, nonwhite males, and nonwhite females.

The Oklahoma resident population by age, sex, race and county was estimated from the 1950, 1960 and 1970 population censuses.

Ideally, we would like to determine whether the disease frequency formed patterns of irregular distribution or was randomly distributed within the State of Oklahoma among the seventy-seven counties. Therefore, based on the mortality experience of the total Oklahoma population from bone cancer over the 20-year period studied, the expected number of bone cancer deaths was estimated for each county based on the proportion of people in the state living in that particular county. A standard mortality ratio was then tabulated for each county using the observed number of deaths for the particular county as the numerator and the expected number of bone cancer deaths as the denominator. The ratio of observed to expected deaths was then multiplied by 100 to obtain the standard mortality ratio for the county. If the observed and expected number of deaths are equal, a standard mortality ratio of 100 would be obtained; while an excess of observed deaths would produce a ratio greater than 100 and thus, indicate an area of excess bone cancer mortality. Conversely, a mortality ratio less than 100 indicates an area of low bone cancer mortality.

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RESULTS

Bone cancer deaths by sex, race and year as well as deaths and rates for the total population by year, from 1950 through 1970 (1955 data missing), are presented in Table 1. Average annual death rates by five-year periods and for the twenty-year study period are also presented. It is worth noting from the data presented in this table that the average annual death rates for bone cancer are 1.8 and 1.2 (per 100,000) for males and females respectively. The annual rates in males and females show a slight decrease in mortality over the twenty-

year period. This decrease is evident if we compare the average annual rates for males for the 1950-54 (2.0), 1956-60 (1.9), 1961-65 (1.7), 1966-70 (1.6) time periods. It is further evident if we compare the average annual rates for females for the 1950-54 (1.5), 1956-60 (1.3), 1961-65 (1.2), 1966-70 (0.9) time periods. This decrease is also reflected in the total number of deaths occurring in each of the four, five-year periods. Though rates were not tabulated by race the data indicate that less than 9.5% of the total deaths occurred among the nonwhite population (67 out of 708). The nonwhite population is a mixture of blacks and Indians. Of the total population, whites account for 90.7% of the population, blacks 6.6%, and Indians

Table 1
Bone Cancer deaths by sex, race and year, and death
rates for the total population by year
Oklahoma, 1950-1970*
(Rates Per 100,000 Population)

Year of death	White		Black		Indian		Tot. (deaths)		Tot. (rates)	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
1950	20	11	1	1	0	1	21	13	1.9	1.2
1951	13	17	3	1	0	0	26	18	2.3	1.6
1952	29	11	0	1	0	0	29	12	2.6	1.1
1953	18	20	0	1	0	0	18	21	1.6	1.8
1954	17	19	3	0	0	0	20	19	1.8	1.7
1950-1954	97	78	7	4	0	1	104	83	2.0**	1.5**
1956	15	11	2	1	0	1	17	13	1.5	1.1
1957	20	14	2	2	1	1	23	17	2.0	1.5
1958	19	20	1	3	0	0	20	23	1.8	2.0
1959	26	15	3	0	0	0	29	15	2.5	1.3
1960	20	7	0	0	0	0	20	7	1.7	0.6
1956-1960	100	67	8	6	1	2	109	75	1.9**	1.3**
1961	17	16	2	1	0	0	19	17	1.6	1.4
1962	14	11	1	0	0	0	15	11	1.3	0.9
1963	12	14	2	3	0	0	14	17	1.2	1.4
1964	19	11	1	2	0	0	20	13	1.7	1.1
1965	32	17	2	0	1	1	35	18	2.9	1.4
1961-1965	94	69	8	6	1	1	103	76	1.7**	1.2**
1966	19	13	3	0	1	2	23	15	1.9	1.2
1967	17	9	0	1	1	0	18	10	1.5	0.8
1968	16	8	3	1	1	0	20	9	1.6	0.7
1969	13	9	4	2	0	0	17	11	1.4	0.8
1970	20	12	0	2	1	0	21	14	1.7	1.1
1966-1970	85	51	10	6	4	2	99	59	1.6**	0.9**
1950-1970	376	265	33	22	6	6	415	293	1.8**	1.2**

*1955 data missing

**Average annual rate

Table 2
Age-Sex-Race Death Rates for Bone Cancer
Oklahoma: 1950-1970*
(Rates Per 100,000 Population)

Age	White Male				White Female			
	1950-54	1956-60	1961-65	1966-70	1950-54	1956-60	1961-65	1966-70
<5	0.9	0.9	0.9	1.1	0.9	0.9	0.0	0.0
5-14	3.2	1.4	2.3	2.3	3.9	3.6	3.4	0.5
15-24	3.8	5.2	4.6	5.7	1.3	6.1	1.4	2.7
25-34	0.7	1.5	1.6	2.3	4.1	1.4	0.0	0.0
35-44	5.9	4.5	1.5	4.0	1.4	2.1	5.2	0.8
45-54	11.4	13.4	7.2	4.0	6.8	4.8	4.5	2.3
55-64	23.0	22.5	31.5	22.6	22.3	13.0	8.3	8.4
65-74	36.5	25.9	28.6	23.7	28.5	9.3	25.3	11.2
75+	63.6	72.1	45.1	34.4	42.0	41.4	32.8	34.0
AADR**	10.1	9.7	8.7	7.5	7.9	5.9	5.6	3.6

Age	Non-White Male				Non-White Female			
	1950-54	1956-60	1961-65	1966-70	1950-54	1956-60	1961-65	1966-70
<5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
5-14	0.0	0.0	0.0	12.1	0.0	3.9	0.0	0.0
15-24	0.0	19.2	0.0	8.3	0.0	0.0	0.0	0.0
25-34	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
35-44	26.8	9.5	0.0	9.0	0.0	0.0	16.7	0.0
45-54	29.8	0.0	10.0	0.0	9.1	17.5	16.9	23.5
55-64	0.0	0.0	22.6	31.6	13.4	11.3	10.0	8.5
65-74	0.0	49.3	63.3	13.4	34.2	31.4	14.7	33.3
75+	36.2	60.6	53.3	7.2	39.4	59.5	24.7	18.9
AADR**	8.1	9.3	9.2	11.1	5.9	8.0	6.8	6.3

*1955 data missing
**Age adjusted death rates based on the 1960 state white males as the standard population

2.7%. Furthermore, the proportional death rates from bone cancer by race are interesting in that 90.0% of the deaths occurred among the white, 7.8% among the blacks and only 1.7% among the Indian population. Also, the annual death rates for the white males are approximately one-and-one half times the female rates. The same is true for the black males and females.

In Table 2 we observe bone cancer, age-sex-race specific death rates by four five-year periods as well as the age-adjusted death rates for the white males, white females, nonwhite males and nonwhite females. It might be generalized, especially in the white population, that there is an increase with age to 15 years at which point the rates drop to age 30 until they begin to rise at age 40 and then increase steadily with age. The age-adjusted death rates show a consistent decrease for white males and females. It is interesting that the age-adjusted death rates for black males have shown an increase (8.1 to 9.3 to 9.2 to 11.1). The black females showed a low rate in the 1950-54 period (5.9), a peak in the 1956-60 period (8.0) and a decrease after 1961 (6.8 to 6.3).

Figure 1 shows the geographic distribution of mortality as expressed in standard mortality ratios. Counties reporting standard mortality ratios above one hundred reflect an increase in the observed mortality above that which would have been expected had the Oklahoma experience prevailed equally for each of the counties in the state. Conversely, standard mortality ratios below 100 reflect a decrease in the observed mortality. Ratios that approximate 100 reflect a mortality experience similar to that for the state. It is obvious from data presented in Figure 1 that counties experiencing high or low standard mortality ratios from bone cancer in Oklahoma are represented in every geographic area of the state. However, there appears to be a number of counties experiencing unusually high ratios worthy of mentioning. Beckham county experienced a SMR of about 205, McIntosh 241, Okmulgee 179. These were significantly high at the 0.05 level of significance. Beaver county experienced a SMR of zero, Harper 0, Latimer 0, Oklahoma 73, Tulsa 78, Major 0. These were significantly low at the 0.05 level of significance.

DISCUSSION

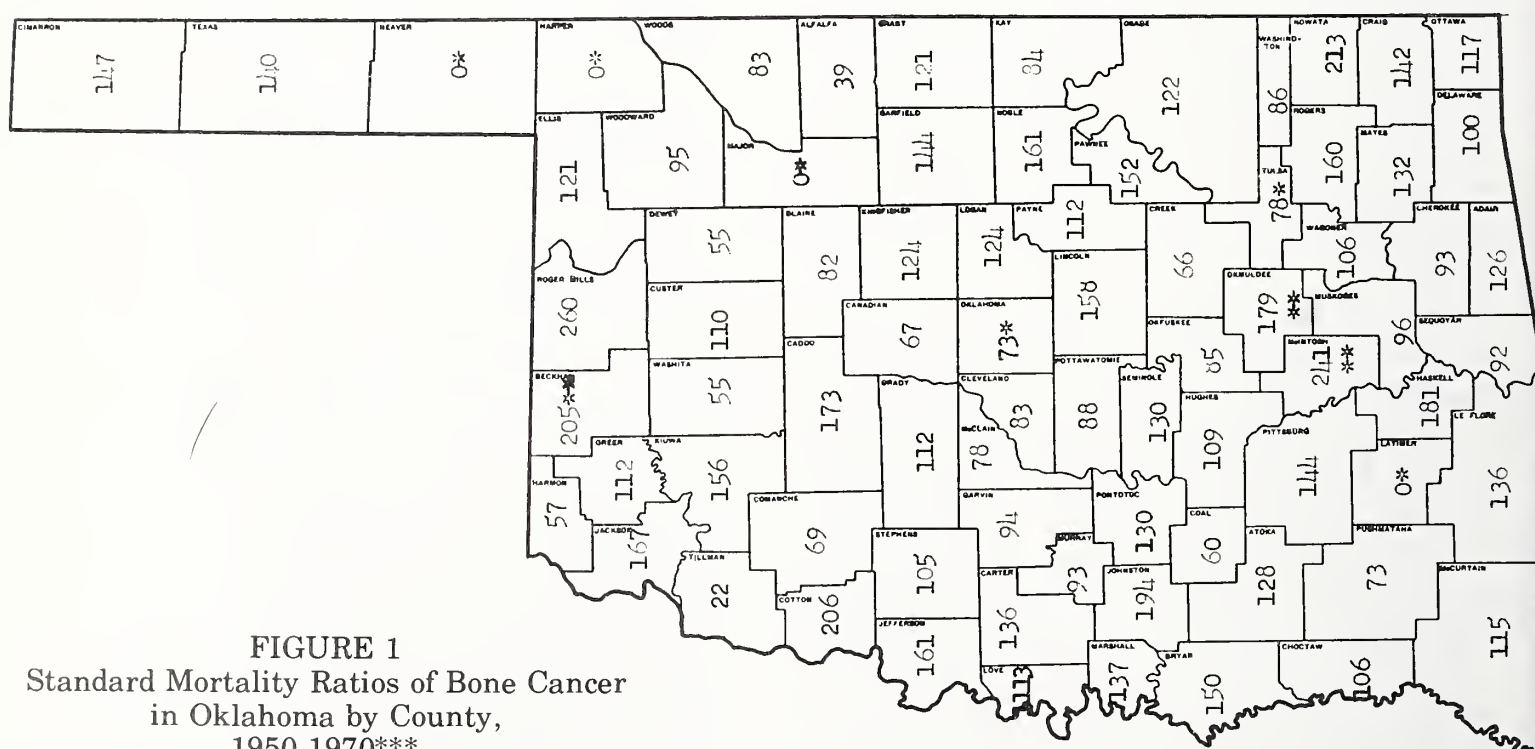
The findings of previous studies on morbidity data on bone cancer have been reasonably consistent in their results. The most obvious similarity found in the previous studies in the field is the rapid increase in the bone cancer death rates from 0-15 years, a decline up to 40 years, and then an increase with age. By age 60 the rates were equal to the earlier peak at age 15 and then continued rising from age 60 upward. In addition there are differences that exist in mortality from bone cancer by age, sex, race. Most of this evidence has been accumulating from mortality as well as morbidity data.

The findings of this study are consistent with the general epidemiologic features of this disease reported elsewhere. The only exception that is particularly noteworthy, is that the crude death rates experienced in this study were considerably higher, but distributed similarly by age as in previous studies. The *annual* crude death rate for males, experienced over a 20 year period in this study, was 118 per 10 million and for females 70 per 10 million. These rates were computed for the 0-64 year age group. The findings of previous studies

were (0-64 age group — rates per 10 million) 62.9 for males and 38.9 for females⁴ and 53.2 for males and 33.4 for females.¹ These two sets of figures are from England and Wales for the periods 1951-3 and 1961-3 respectively.

Since the cause of bone cancer remains unclear, it is not expressly easy to apply descriptive results with meaning. The hypothesis that the growth-spurt during adolescence accounts for the increase of bone cancer in those age groups doesn't explain why the rates are so high in the older ages. What meaning can be placed on the increased rate in males over females is not clear. The results as to racial distribution show that the disease is not significantly higher in one race than another. Why the disease seems to be increasing with time in the nonwhite males and very slightly in the nonwhite females is unclear. Perhaps diagnostic facilities and better medical care are becoming more available to this segment of the population. Bone cancer which was not diagnosed in the past is now brought to the attention of health officials.

There does seem to be a slight trend for the Indian population to have slightly lower representative rates whereas the black population seems to experience a very slight increase in mortality. This is not unusual, as the Indian population is reported to have experienced re-



*** 1955 data missing

*Significantly low at the 0.05 level

**Significantly high at the 0.05 level

duced mortality from many other cancer sites and hence may reflect more the experience of oriental countries than western countries.

SUMMARY

Deaths from bone cancer occurring to residents of Oklahoma from 1950 to 1970, excluding 1955, were analyzed. Age-specific death rates and age-adjusted rates were tabulated for four, five-year periods by sex and race. A standard mortality ratio was tabulated and plotted on Oklahoma maps by county.

A decrease was reported in the annual death rate for males and females over the 20 year-period. One and a half times as many deaths were observed among white and black males as in the females. In the Indian population the male-female ratio for bone cancer was unity.

An increase in the bone cancer mortality was found with an increase in age with a minor

peak at 15-19 years and the maximum being reached after age 60—at which point the rates steadily increased with age.

Another significant finding was the low mortality experienced by the Indian population of Oklahoma. □

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Overdosage should be avoided in patients severely ill with ulcerative colitis.

Adverse Reactions: Varying degrees of drying of salivary secretions may occur as well as mydriasis and blurred vision. In addition the following adverse reactions have been reported: nervousness, drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

Dosage and Administration: The recommended daily dosage for adult oral therapy is one 15-mg. tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

How Supplied: Pro-Banthine is supplied as tablets of 15 and 7.5 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg.

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Maimonides And His Scene

SOLOMON PAPPER, MD

Maimonides achieved greatness as a theologian, philosopher and physician. Selected contributions to each of these spheres are presented. He demonstrated by example that medicine should not be a circumscribed field; rather it is concerned with all truth, knowledge and wisdom for human purposes.

Maimonides earned prominence among experts as a theologian, as a philosopher and as a physician. I shall explore selective aspects of the man, his times, and his work in all three areas of knowledge.

It often helps to understand a scholar's works if one has some knowledge of personal motivation and the times in which he lived and worked; this is certainly true of Maimonides.

THE INTERNAL ENVIRONMENT

Maimonides was a pious Jew with very Jewish perspectives. Life for him was *not* divided into religious and secular spheres, but rather *all* experience and knowledge, even the so-called secular were interpreted in terms of religious outlook. The essence of this particular religious perspective is unity; the unity

Presented at the History of Medicine Society meeting, February, 1975.

which necessarily follows from a belief in *one* God who willed into being the entire cosmos, and whose continuing will that it exist is required to maintain it. If these are the basic assumptions, it follows that scientific observations *by definition are not and cannot* be at odds with religious experience; and when they appear to be this is a distortion caused by inadequate knowledge. The deeply religious person in this context is *not* required to *reconcile* religion and science. As he gains knowledge and wisdom he will inevitably come to learn and see the oneness and integration of all valid science, philosophy and religion. Among the many with this orientation, Maimonides is pre-eminent in *seeking underlying unity* in God in all knowledge and experience.

It is this total perception that allowed Maimonides to make a basically religious statement, which, out of context might be regarded by some as irreligious. He said, "The advancement of learning is the highest commandment."

With this as a fundamental aspect of the internal setting of the man, let us consider briefly his external environment.

THE EXTERNAL ENVIRONMENT

Maimonides was born in 12th-century Spain, a time and place of special meaning. In seventh- and eighth-century Spain, Jews were officially given slave status, their personal possessions were confiscated and they were ordered to convert to Catholicism, be executed, or leave the

Maimonides / PAPPER

land. It should be no surprise that during that time Spanish Jews were watching with considerable interest and hope the rise of the Moslems and their dramatic advances over Arabia, Western Asia, and North Africa. The Moslems had a record in North Africa of regarding all Christians and Jews as "protected infidels." The Moslem conquest of Spain in the year 711 was therefore welcomed by the Jews and ushered in for them and the rest of the world almost seven centuries of relative enlightenment. Division within the world of Islam placed its Eastern seat in Baghdad and its Western base in the city of Cordova in southern Spain — the city of Maimonides' birth. Under Arab rule, Spain flourished educationally, culturally, in agriculture, in science, and in its standard of living.

While this was happening in Spain, Egypt under Moslem rule was undergoing a rebirth of its more ancient glory with considerable improvement in the lives of its many Jews. Although discriminatory laws existed in Arab Spain and Egypt, Jews experienced a measure of freedom, opportunity, and position they were not to know again anywhere in the world for more than 500 years.

One student of this portion of world history (Abba Eban), wrote:

Four hundred years before the European Renaissance the lands of the Arab Empire experienced a rebirth of culture that in intensity and scope, as well as in the sheer quantity of its achievements, equalled, if it did not surpass, any similar period in human history. In philosophy and science, in theology, literature and language, an astonishing range of talent and innovative genius was applied to the verbalization of man's quest to know, and to the expression of man's thirst to enjoy.

Blending the knowledge of Greece with Eastern perspectives, the Arabs further developed the arts and sciences; under their rule medicine attained a status unsurpassed until modern times. The Arab-Jewish interaction in this era contributed vastly to the history of civilization and to the subsequent deliverance of Europe out of the Dark Ages.

THE MAN

Maimonides, born in 1135 in Cordova, Spain, was a benefactor of this great Arab develop-

ment, experienced and survived its dissolution by the Almohades in Spain to travel to Egypt where he entered a noble civilization similar to what Spain's had been.

Moses ben Maimon, *ie*, Moses the son of Maimon was his name. He is also known as the Maimoni, hence Maimonides. He is also referred to as RaM BaM from the initials of Rabbi Moses ben Maimon. (In Haifa, Israel for example there is the Rambam Hospital.) Maimonides came from a prominent family of scholars and communal leaders; his father was a judge. While little is known of the details of Maimonides' early life and education, it is evident that he learned a great deal of mathematics, astronomy, astrology, philosophy, theology, Jewish studies and medicine. Specifically it is not known from whom he learned medicine. Because of Maimonides' earlier interest in theology and philosophy and only later active role as a physician, it has been assumed that he learned medicine as a peripheral activity while giving greater emphasis to other aspects of learning. His education and early life were designed so as to prepare him to follow family tradition as a Rabbi.

In the year of 1148 when he was 13 years old his life was badly shaken. The city of Cordova was the site of a Moslem civil war. The visitors were the Almohades, a sect who offered Jews and Christians the alternatives of death or conversion to Islam. Maimon and his family illegally fled the city at great risk to themselves and began 18 years of wandering over incredible distances through Spain, Africa and the Land of Israel. Finally in 1166 at the age of 31, Maimonides arrived in Egypt where he lived with dignity in a safe haven until his death at age 70 years. There he first became a practitioner of medicine, at least in part to support himself and his dead brother's family. His professional reputation expanded rapidly

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and he was soon appointed personal physician to the Sultan. Maimonides became known beyond Egypt and he received and rejected an invitation to be physician to King Richard I of England.

Aside from Maimonides' father, who persevered through the 18 years of wandering only to die the year the family arrived in Egypt, relatively little is known of the family. We know Maimonides had a brother who was a jewel merchant and who died in a shipwreck during their years of exile. And we know little of Maimonides' mother and wife; and I know only of vague references to a son.

Similarly little is written of Maimonides' personality, temperament and disposition; much has to be surmised. However there is some evidence that he regarded himself as sickly most of his life.

But we do know how revered he was in his time. His greatness did not have to wait for death or the passage of the centuries to be recognized.

When Maimonides died, the Jews and the Moslems of Cairo had public mourning for three days and in Jerusalem there was a day of fasting. Legend has it that his body was placed on the back of a donkey for burial wherever the body dislodged. He was buried in Tiberias, on the Sea of Galilee where his tomb remains a place of pilgrimage. An Egyptian medical historian wrote a poem about him for his funeral:

If the moon would submit to Abu Imram
(Maimonides') art,

He would heal her of her spots,
Cure her of her periodic troubles,
And keep her from ever waning.

Jews cherished him as reflected in the saying, "From Moses to Moses there arose none like unto Moses," with the implication that he was regarded as a second Moses. Subsequently the site of his birth in Spain was honored and named Plazuelce de Maimonides.

THE THEOLOGIAN

In a ten-year period from age 23-33 years, mostly accomplished during the period of his wanderings, Maimonides' first religious work was completed — he wrote the Commentary on the Mishna. The Mishna is the compendium of Jewish *Oral* Law which includes civil law, criminal law, ethics, and health matters. It was written in Arabic, the language Maimonides preferred although he was also

fluent in Latin and Hebrew. His most famous religious work, the *Mishna Torah* was completed in the year 1180 at age 45 after ten years of work. The *Mishna Torah* is a clarification and codification of the whole of Jewish Laws, topic by topic, arranged systematically in 14 books. To do this Maimonides had to have an encyclopedic knowledge of the Bible and the Talmud. These two religious works established Maimonides as an outstanding rabbinical scholar called upon by Jews to arbitrate debates and clarify Jewish Law while serving to explain for the first time to the gentile world what Jewish Law was and what it meant.

THE PHILOSOPHER

Although he published his first philosophical treatise entitled *The Art of Logic* at age 16 the crown of his philosophic achievements was not published until he was 55 years old. It is entitled *The Guide for the Perplexed* and was written in Arabic. Maimonides intended this work to be a guide for "thinkers whose studies have brought them into collision with religion." Because of the increasing Arab interest in Greek philosophies at the time, especially Neoplatonic Aristotelianism, much of the Guide interprets biblical and rabbinical theology in these terms. The Guide considers the figurative and literal meanings of the Scriptures; the existence of God, and the nature of evil, of providence, of the design of nature and of moral virtues. It shows how Biblical precepts are intended to perfect man either by imparting knowledge to him, by improving his moral conditions, or by guaranteeing the well-being of Society. The Guide also includes an important break with Aristotle. The latter accepted the doctrine of the eternity of the world. Maimonides rejects this because it puts a limit on a God who is not tied to the inevitability of any phenomenon He does not will. This concept was of major significance to the subsequent Christian Scholastics.

Let me sample only a few quotes from the Guide.

The spiritual perfection of man consists in his becoming an actually intelligent being . . . Such knowledge can be obtained not by mere virtue and righteous conduct alone, but through philosophical inquiry and scientific research.

There are three causes which prevent men from discovering the exact truth:

first, arrogance and vainglory; second, the subtlety, depth and difficulty of any subject which is being examined; third, ignorance and want of capacity to comprehend what might be comprehended.

And there is a fourth cause; viz, habit and training. We naturally like whatever is familiar, and dislike whatever is strange . . .

A truth, once established by proof, neither gains force by the consents of all scholars, nor loses certainty because of the general dissent.

He who has studied insufficiently, and teaches and acts according to his defective knowledge is to be considered as if he sinned knowingly.

Do not consider a thing as proof because you find it written in books . . .

Wisdom is the consciousness of self.

Moral conduct is a preparation for intellectual progress, and only a man whose character is pure, calm and steadfast can attain to intellectual perfection . . .

A miracle cannot prove that which is impossible; it is useful only as a confirmation of that which is possible.

It is of great advantage that man should know his station, and not erroneously imagine that the whole universe exists for him alone.

It is in the nature of man to strive to gain money and to increase it; and his great desire to add to his wealth and honor is the chief source of misery for man.

It is indeed a fact that the transition from trouble to ease gives more pleasure than continual ease.

The philosophical and theological works of Maimonides had an enormous influence on subsequent Christian scholastic theologians especially St. Thomas Aquinas and Albertus Magnus. The resurgence in the 13th century of the Aristotelian emphasis on purely observable physical phenomena was regarded by many Christians as a threat to spiritual perspectives and true faith. Saint Thomas Aquinas and Albertus Magnus dealt particularly with the perspective that the "new" naturalist emphasis could be harmonized and reconciled with Christian truth. In doing so they made extensive use of Maimonides' *Guide for the Perplexed*. In fact many of Maimonides'

writings were placed for safe-keeping in the Pope's library where they still remain.

THE PHYSICIAN

And finally let us turn to something of Maimonides' relation to medicine. We have already indicated his wide reputation as a *practitioner* of medicine and his special role as physician to the Throne in Egypt.

He wrote of his daily routine:

I dwell at Mizr (Fostat) and the Sultan resides at Kahira (Cairo); these two places are two Sabbath days' journey (about one mile and a half) distant from each other. My duties to the Sultan are very heavy. I am obligated to visit him every day, early in the morning; and when he or any of his children, or any of the inmates of his Harem, are indisposed, I dare not quit Kahira, but must stay during the greater part of the day in the palace. It also frequently happens that one or two of the royal officers fall sick, and I must attend to their healing. Hence, as a rule I repair to Kahira very early in the day, and even if nothing unusual happens, I do not return to Mizr until the afternoon. Then I am almost dying with hunger. I find the antechambers filled with people, both Jews and Gentiles, nobles and common people, judges and baliffs, friends and foes — a mixed multitude, who await the time of my return.

I dismount from my animal, wash my hands, go forth to my patients, and entreat them to bear with me while I partake of some slight refreshment, the only meal I take in the twenty four hours. Then I attend to my patients and write prescriptions and directions for their several ailments. Patients go in and out until nightfall, and sometimes even, I solemnly assure you, until two hours and more in the night. I converse with and prescribe for them while lying down from sheer fatigue, and when night falls I am so exhausted that I can scarcely speak.

In consequence of this, no Israelite can have any private interview with me, except on the Sabbath. On that day the whole Congregation, or, at least the majority of the members, come to me after the morning service when I instruct (advise) them as to their proceedings during

the whole week; we study together a little until noon, when they depart. Some of them return, and read with me after the afternoon service until evening prayers. In this manner I spend that day.

While his medical writings were limited to the last two decades of his life they revealed his vast knowledge of then current theory and his own ability to observe, analyze, accept or discard. He was also opposed to non-observational medicine, and he even criticized Galen whose stature and influence on Arab medicine were great. In an era of blind acceptance of the voice of authority, Maimonides wrote, "Dear is Galen, but dearer is Truth."

He elaborated a bit more on the point as follows:

. . .if any man declares to you (that he has found) facts that he has observed and confirmed with his own experience; even if you consider this man to be more trustworthy and highly authoritative, be cautious in accepting what he says to you . . . you should think (critically) and understand (what he means) when he declares that he has observed it . . . investigate and weigh this opinion or that hypothesis according to requirements of pure logic, without paying attention to his contention that he affirms empirically. (This is so irrespective of) whether this assertion is advanced by a single person or by many who adhere to that particular viewpoint.

Unlike many if not most of his contemporaries and predecessors, Maimonides had no respect for magic and superstition, and had no use for astrology which he had studied extensively. He wrote, ". . .the science of the stars (*ie*—astronomy) is a true science." Astrology, on the other hand he wrote was, "Not a matter of science, but sheer stupidity."

All of his medical works were written in Arabic, his major language and the language of science and philosophy of the age.

While there is some doubt about the authenticity of some of his medical writings, there are ten treatises about which there is no doubt: 1. Book on asthma; 2. Poisons and their antidotes; 3. Guide to good health; 4. Aphorisms of Moses; 5. On cohabitation; 6. Commentary on the Treatises of Hippocrates; 7. On hemorrhage; 8. Medical responsa; 9. The names of drugs; 10. A compendium of the Treatises of Galen.

I have selected some of Maimonides' medical writings to quote and consider with you. For

convenience I have subdivided these into quite arbitrary categories according to subject.

First let us consider some of Maimonides' *general attitudes toward medicine*.

Maimonides dwelled at length on the psychological motivation of the true physician and warned against the bad physician and the elusive term "experience" as used by the ill-trained and ignorant physicians and quacks. He contended that training in the art of medicine should consist of a combination of practice and theory. This was innovative thinking.

Maimonides considered Medicine more than a means of conquering disease. It was the art of healing people. Treatment of the individual, by taking into account psychological and environmental factors that were unique in each and every case, was for Maimonides a prerequisite to the patient's physical and emotional recuperation. He stated that "the physician should not treat the disease but the patient who is suffering from it."

General Health Measures recommended by Maimonides were:

For the regulation of health, one should begin with gymnastics, followed by food and drink, and then coitus and sleep. One should indulge in each of these five to a moderate degree.

The most beneficial of all types of exercise is physical gymnastics to the point that the soul becomes influenced and rejoices . . . because emotions of happiness (often) suffice (to heal) just by their presence. Thus rejoicing and happiness alone will make many people's illness milder. For others, both the illness on the one hand as well as the emotional upset that led to it disappear.

It is important to pay more attention to exercise of the soul than exercise of the body, according to the higher state of the soul over the body. One should devote oneself in all manner of exercise to the development of happiness, contentment and rejoicing.

. . .the good foods, that ought to be adopted by every one who desires the continuation of his health, are wheaten bread properly prepared . . . it should be made from fully ripened wheat, dried of its superfluous moisture . . . The bread should be made of coarse flour; that is to say, the husk should not be removed and the bran should not be refined by sifting. It should be well raised . . . it should be

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well worked during kneading, and should be baked in the oven. This is the bread that . . . is the best of foods.

Principles of Therapeutics:

He wrote in the 12th century, that "the clever, skilled physician who is versed in the fundamentals of medicine and thinks twice before he decides how to bring about a patient's relief, such a man always relies on the work of nature and keeps her from going lazy."

Maimonides approached therapy in a manner that is still relevant. He divided therapy into *weak* and *strong* and proposed the use of the weaker treatments first.

I shall declare what the *strong* remedies are. They are phlebotomy with the extraction of much blood; evacuation by violently attractive purgatives . . . evacuation by vomiting with the strong medications . . . the deprivation of nourishment in its entirety . . . the prohibition of drinking water and the endurance of thirst; taking multiple adjuvants . . . All these are very strong remedies, and one ought not to have a thing to do with them except on the advice of a physician of surpassing knowledge, because all of these things, when they hit their mark, cure the sick instantaneously or within a short time, or deliver them from death, but if they miss their mark, they usually kill at once, or they engender an illness that ultimately leads its host to death; therefore one should be beware of them.

As for the *weak* medications, they are: the extraction of blood by scarification of the legs or the upper parts of the body; softening the belly with the two mannas; emesis with barley water, or oxymel; lightening the food by taking the customary drinks prepared from sugar, or honey, or barley water, or *kashk* of barley, or soaked bread crumbs, or a little bread in a broth for the sick; medication with the healthy medicaments, that is to say, things that are often taken by the healthy . . . All these are light remedies; if they hit their mark they benefit and cure the mild illnesses, and they can in time cure severe illnesses. If they miss their mark,

they do not kill, or cause great damage; you find therefore that most physicians resort to these and their like among the remedies in seeking security.

The use of medications is pursued as follows:

Whenever it is possible to manage with a simple medicament they should not manage with the compounded, and if it is not possible without the compounded, they should manage with one of lesser complexity. They should not resort to very complex medicaments except when absolutely necessary. Indeed, it behooves one to be most diligent and never rush to the stronger medicament or be inclined to those that are multiple, but to be content with what is customary among the lighter regimes.

Nourishment is considered:

Likewise, when uncertain whether to feed the sick or prohibit food altogether, we should feed them with light nourishment . . . One should take a little of what is customary, and always maintain his strength by taking nourishment . . . *light nourishment like chicken soup* . . .

Surgery:

If one is considering excising something from the body, one should devote one's attention in three directions. The first of these is to complete one's work in the shortest possible time. The second is that no pain should be felt at all during the surgery, and the third is that one should be convinced of the outcome. The latter condition has three prerequisites. The first is that it should be clear that one's intent can be absolutely completed; secondly, if one's intent is not (successfully) completed, the patient should not suffer any damage from tangential causes, and thirdly, one should be convinced that the illness will not return. If one pays heed to these conditions, then it becomes clear that sometimes surgical intervention is more salutary, whereas other times the use of medications is preferable.

Emotions and Medicine:

It is known . . . that passions of the psyche produce changes in the body, that are great, evident and manifest to all . . . On this account, the physicians have directed that concern and care should al-

ways be given to the movements of the psyche; these should be kept in balance in the state of health as well as in disease, and no other regime should be given precedence in any wise. The physician should make every effort that all the sick and all the healthy, should be most cheerful of soul at all times, and that they should be relieved of the passions of the psyche that cause anxiety. Thereby the health of the healthy will persist. This is also foremost in curing the sick, . . . the skillful physician should place nothing ahead of rectifying the state of the psyche by removing these passions. Nonetheless, the physician, inasmuch as he is a physician, should not insist upon his own art as the rationale for the strategem in removing these passions, for truly, this virtue is to be attained from practical philosophy and from the admonitions and disciplines of the (Religious) Law . . . people nurtured in the philosophy of morals, or in the disciplines and admonitions of the Law acquire strength of mind, and they are truly strong. Their psyche does not change and is affected as little as possible. The more a person is disciplined, the less is his agitation in both these states, namely, in the state of prosperity and in the state of adversity.

This servant has only meant by these references to suggest training the psyche to restrain the passions by studying books on morals, the disciplines of the Law and the admonitions and the laws spoken by the sages. Thus the psyche will be strengthened and will see the true as true and the false as false. The passions will diminish, the evil thoughts will depart, the depression will lift, and the psyche will dilate in whatever situation a man might encounter. (I note how much of this perspective is in Dr. Meninger's most recent book, "Whatever Became of Sin!?")

Here contemplation is very good; it will reduce evil thoughts, anxiety, and distress. If one reflects on something and becomes distressed by the thought, and grief, sorrow, and sadness arise in him, this can come from one of two things. Either he thinks about something that has passed, like thinking about what has befallen him from the loss of wealth that was his or the death of someone for whom he grieves, or he thinks of things that

might yet happen and fears their coming, like thinking and dwelling upon what might result from the coming of adversity. Yet it is known through rational observation, . . . that sorrow and gloom about things that have come and passed are the occupation of fools. (Note a recent proverb even sold on greeting cards: 'Do not allow yesterday to use up today'.)

As for obsession with thoughts about what might befall in the future that lead to anxiety, these ought also to be relinquished with the consideration that everything that one might anticipate lies in the realm of possibility; it might happen or might not happen.

One who suffers from melancholia can sometimes rid himself of it by listening to singing and instrumental music, by strolling through beautiful gardens and splendid buildings, by gazing at beautiful pictures, and other such things that enliven the mind and dissipate gloomy moods.

Thus, just as the body becomes exhausted by hard labor, and is reinvigorated by rest, so is it necessary for the mind to have relaxation by gazing upon pictures and other beautiful objects, that its weariness may be dispelled.

Sickness of the Soul:

It is a well-known assertion of philosophers that the soul can be healthy or diseased, just as the body is either healthy or diseased. These illnesses of the soul and their health which are alluded to by philosophers undoubtedly refer to the opinions and morals of people. Therefore, I consider untrue opinions and bad morals, with all their different varieties, as types of human illness. Among these human illnesses, there is one disease which is so common that I think that no one can escape it . . . The illness to which I refer here consists of the fact that every individual person considers himself more perfect than he really is, and desires and lusts that all that enter his mind should possess perfection, without effort and fatigue. (Among sufferers) of this common illness one finds people who are otherwise clever and wise . . . Such a person then gives opinions not only in the (field) he has mastered, but also in other sciences

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concerning which he knows nothing at all, or in which his knowledge is deficient.

I have elected to give less attention to Maimonides' writings in specific disorders. There are however many examples of extraordinary insights: he recognized asthma as having many etiological aspects including colds, rhinitis and environmental factors; he knew a great deal about plant and animal poisons including a vivid description of hemolytic and neurotoxic snake venom; and there are many perceptive observations on the circulation, diabetes, as well as other conditions.

In summarizing Maimonides the physician — he apparently was good at the Art of Medicine and had a good knowledge of theoretical principles of the time. New for his period was his questioning attitude and the emphasis on reason and the need for observation — the beginning steps of scientific medicine. Maimonides was keenly aware of the emotional aspects of medicine. His approach to Medicine was sophisticated, including the elegantly simple principle to do no harm.

SUMMARY

We can conjecture uselessly whether it was Maimonides the philosopher that dominated over the physician, or the physician-scientist who guided the philosopher. The fact is there was no compartmentalization in his life; he preached what he believed to be true, and he practiced what he preached. Medicine, religion and philosophy were always closely interwoven in all his works. He influenced favorably his own era and the future of philosophy, theology and medicine.

The messages for ourselves in learning from Maimonides are too many to be summarized and probably are quite individual. For me, the lessons are that: Medicine is not really a cir-

cumscribed field; we develop through a concern for human purposes; this development occurs through serious efforts to acquire knowledge and wisdom, which in this context include compassion and justice.

I would like to close with reading the respected Maimonides' Prayer. It says much of the man and his profession of medicine:

I begin once more my daily work. Be Thou with me, Almighty Father of Mercy, in all my efforts to heal the sick. For without Thee, man is but a helpless creature. Grant that I may be filled with love for my art and for my fellowman. May the thirst for gain and the desire for fame be far from my heart. For these are the enemies of Pity and the ministers of Hate. Grant that I may be able to devote myself, body and soul to Thy children who suffer from pain.

Preserve my strength, that I may be able to restore the strength of the rich and the poor, the good and the bad, the friend and the foe. Let me see in the sufferer the man alone. When wiser men teach me, let me be humble to learn; for the mind of man is so puny and the art of healing is so vast. But when fools are ready to advise me or to find fault with me, let me listen to their folly. Let me be intent upon one thing, O Father of Mercy to be always merciful to thy suffering children.

May there never rise in me the notion that I know enough, but give me strength and leisure and zeal to enlarge my knowledge. Our work is so great and the mind of man presses forward forever. Thou has chosen me in Thy grace to watch over the life and death of Thy creatures. I am about to fulfill my duties. Guide me in this immense work so that it may be of avail. □

921 N.E. 13th Street, Oklahoma City, Oklahoma 73104

Remember these dates —

May 6th, 7th, 8th, 9th, 1976

OKLAHOMA MEDICAL SUMMIT '76

Lincoln Plaza Forum

Oklahoma City, Oklahoma

This will be a combined meeting of the Oklahoma State Medical Association, the Oklahoma City Clinical Society and the Oklahoma Academy of Family Physicians.

Task Force on Medical Care of the Vietnamese Child

The American Academy of Pediatrics has established an ad hoc task force on Medical Care of the Vietnamese Child which met at the O'Hare Airport on April 21, 1975, to consider the health problems of these arriving children and their adoptive families. The task force was chaired by Henry M. Seidel, MD, Chairman of the AAP Committee on Adoption and Dependent Care, and included Ruth C. Harris, MD, Medical Consultant to the Holt Adoption Program, Inc., and member of the AAP Adoption Committee; Donald Lewis, MD, Consultant to the AAP Adoption Committee; and John D. Nelson, MD, Consultant to the AAP Committee on Infectious Diseases and a Consultant to Nhi Dong Hospital, Saigon.

The task force has been in touch with the Center for Disease Control and the Bureau of Community Health Services at HEW, with the Agency for International Development, and with physicians in centers where large numbers of Vietnamese children have recently been screened. 1,900 Vietnamese children had arrived in the United States at the time of the meeting, and more were reported enroute. With this in mind, the task force met to review medical data available on these children and to alert physicians who will be caring for these children to their special medical needs and to important health considerations as the children enter the mainstream of American medical care.

The following statement was prepared by the task force at the conclusion of their meeting. Because of many requests for this information, the statement was released to the major media at that time.

American Academy of Pediatrics MEDICAL CARE OF THE VIETNAMESE CHILD

There has been some expression of concern about the health of the Vietnamese children who have recently come to the United States. This concern has two focuses:

- 1) the personal health of the individual child;
- 2) the possible threat to public health in the United States.

Agencies including the Center for Disease Control, the Agency for International Development, and numerous private organizations and physicians in the United States are concerned with the arriving Vietnamese children and have learned about them as individuals and as a group. We have reviewed the available information and certain things are clear. There is no evidence at all of any disease which requires quarantine. There is no evidence at all of any disease which is of a unique or serious nature which might be introduced into this country.

Obviously, many of these children — because of problems of a country at war — are malnourished and poorly cared for in terms of both acute and chronic illness. Their acute illnesses are those which are commonly seen in the United States; but because their chronic diseases may have received no medical attention, they may occur in the Vietnamese children with greater frequency and intensity than we customarily see. However, given appropriate medical attention these diseases are manageable or self-limiting. Certainly, one of

Vietnamese Child

the major needs is attention to the immunization status of these children.

Foresight about probable infections of children from underdeveloped countries will expedite improved health in these children and prevent disabilities in adopting families. Surveys completed in 1972 of 700 families and in 1974 of over 900 families adopting infants and children from Asian countries show that 83% of these children developed acute illness during the initial six months. Diarrhea occurred during the first month in 42%. Persistent problems include ear (25%) and upper respiratory infections (28%). Chronic diarrhea due to parasitic infestations (7%), shigella, salmonella, virus infection, and milk intolerance have occurred. Skin infections have included eczematoid impetiginous rashes associated with scabies (1-5%). Like scabies, lice (8%) may also spread to the rest of the family. Molluscum contagiosum, staphylococcal boils, styes, and conjunctivitis (possibly trachoma) have also been noted.

Intestinal flu, hepatitis, or infectious mononucleosis has occurred in about 2% of families within the first four months of the child's arrival. Rarely a family has had salmonella, shigella, or amebiasis in several members. It is incorrect to blame the new arrival for all family illnesses, but awareness and special care to prevent spread of infection is mandatory.

The following are important medical considerations in the evaluation of the Vietnamese child:

1. Diarrhea and Intestinal Parasites

Bacterial diarrhea: Diarrhea due to *Shigella*, *Salmonella* and *E. coli*, which ordinarily is an acute, relatively brief illness, may persist in malnourished children. Therefore, even if a child has chronic diarrhea, these infections are a possibility. Many of these organisms may be broadly resistant, because of prior antibiotic administration, so it is important to obtain sensitivity tests as well as cultures. These are contagious forms of diarrhea and call for appropriate precautions including hand washing, careful disposal of stools, etc.

Parasites: All the Vietnamese children should have three stool examinations for ova and parasites, done by competent laboratories. Parasites commonly present are: hookworm, *Giardia lamblia*, ascaris, and ameba.

2. Dehydration

On arrival, many of the children have been found to be dehydrated. Prompt treatment should be available.

3. Hepatitis

In preliminary observations, hepatitis B appears to be quite common among these children, as in children of many developing countries. We do not recommend routine screening for hepatitis B antigenemia. Children with clinical evidence suggesting hepatitis should have appropriate laboratory tests for confirmation of the diagnosis. If hepatitis B is found in one of these children, gamma globulin is *not* recommended for household contacts, as it is of no value.

In the presence of clinical hepatitis with a negative test for hepatitis B, the presumptive diagnosis is hepatitis A, and immune serum globulin is indicated for household contacts.

4. Tuberculosis

Many of these children will have received BCG shortly after birth. This commonly leaves an elevated scar on the arm, thigh, or foot. Therefore, a positive skin test for tuberculosis may reflect BCG immunization rather than active tuberculosis.

Children with a positive skin test should have a chest x-ray, but if there is no evidence of pulmonary or extra-pulmonary illness, they need only be observed and do not require treatment.

5. Need for immunizations

It is probably prudent to assume that vaccination records may not be accurate, and to perform primary immunizations according to routine schedules on all these children.

6. Dermatitis

Scabies is very common in Vietnamese children. In infants, scabies may cause a generalized rash, rather than the characteristic pattern, and the skin may not have burrows but only a papular/vesicular eruption. Treatment with gamma benzene hexachloride ("Kwell") is effective, and the usual precautions concerning linen and clothing should be observed.

Molluscum contagiosum, pyoderma, and many other skin problems may be present.

7. Pneumonia

Vietnamese children may arrive with lung infections. *Pneumocystis carinii* pneumonia has occurred on rare occasions in severely debilitated Vietnamese orphans.

8. Otitis media

The arriving children may have active mid-

dle ear infections, or evidence of old infections in the form of perforated eardrums and/or chronic drainage. Careful evaluation is indicated.

9. **Meningitis**

Because many of the children have left under hurried conditions, a number of acute infections may be incubating, including meningitis. Again, it is important to remember that prior, indiscriminate treatment with antibiotics may have been given.

10. **Conjunctivitis**

Trachoma should be considered in the differential dagnosis of conjunctivitis. It should also be kept in mind that conjunctival dryness and corneal ulcers may be symptoms of vitamin A deficiency.

11. **Chickenpox and Rubeola**

It is quite possible that all children may be carrying these infections.

12. **Malaria**

Malaria is extremely unusual in infants, particularly those from Saigon. In unexplained fevers of older children, malaria should be considered.

13. **Vitamin Deficiency Diseases**

These are rather common, particularly riboflavin deficiency.

AMERICAN ACADEMY OF PEDIATRICS

Task Force on Medical Care

of the Vietnamese Child

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DATE	TITLE	SPEAKER
September 18th	Clinical Pharmacology I	Thomas L. Whitsett, MD
September 25th	Clinical Pharmacology II	Thomas L. Whitsett, MD
October 2nd	Solid Tumors	Richard Bottomley, MD
October 9th	Hematologic Oncology	Richard Ishmael, MD
October 16th	Immunology I	Samuel R. Oleinick, MD
October 23rd	Immunology II	Samuel R. Oleinick, MD
October 30th	Neurology I	John W. Nelson, MD
		Donald L. Landstrom, MD
		L. D. Amick, MD
November 6th	Neurology II	John W. Nelson, MD
		Donald L. Landstrom, MD
		L. D. Amick, MD
November 13th	Hyperlipoproteinemia	Thomas F. Whayne, MD, PhD
November 20th	Genetics	J. Rodman Seely, MD
December 4th	Bleeding Disorders	Richard Marshall, MD
December 11th	Rheumatology	Russell T. Schultz, MD
December 18th	Allergy/Immunology	James H. Wells, MD

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Oklahoma Immunization Action Month, October, 1975

The goal of the Immunization Program is to locate and immunize susceptibles to diseases preventable through immunization-measles, rubella, polio, diphtheria, tetanus and pertussis. To achieve this goal, a major immunization awareness campaign has been scheduled for October, 1975. This campaign is a part of the National Immunization Action Month Program sponsored by the Center for Disease Control and supported by national, state and local medical associations, voluntary action groups and pharmaceutical companies.

The IAM awareness program is designed to increase the immunity level of Oklahoma's preschool children by placing increased responsibility for adequate immunizations on physicians and parents. Physicians will be encouraged to audit their patient's immunization records. Each time a record is pulled, the vaccination status of the patient should be determined. If the patient is susceptible to the diseases in question arrangements for vaccination should be made. Parents will be encouraged to



News From The Oklahoma State Department of Health

perform their own vaccination audits of their children. If there are questions, parents will be asked to contact their physician or public health offices for assistance.

The major emphasis of the October Immunization Action Month Program will be directed toward 1-4-year-old children. The program will encourage a systematic review and updating of the immunization status of those currently in private or public health care systems. IAM will motivate, encourage, influence or otherwise direct those who are currently not in one system or the other to enlist in such a system.

The success of Oklahoma's Immunization Action Month, October, 1975, will depend heavily upon physician participation. You can support this effort by reviewing your patient's immunization records and reminding parents of the need for vaccination of susceptible children. ☐

COMMUNICABLE DISEASES IN OKLAHOMA FOR JULY 1975

DISEASE	July 1975	July 1974	June 1975	Total To Date	
				1975	1974
Amebiasis	7	4	3	16	14
Brucellosis	—	2	—	3	6
Chickenpox	20	11	37	944	800
Encephalitis, Infectious	10	8	4	31	39
Gonorrhea (Use Form ODH-228)	1133	1057	1112	7254	6284
Hepatitis, A, B, Unspecified	54	78	72	495	643
Leptospirosis	—	—	—	—	—
Malaria	—	2	—	1	3
Meningococcal Infections	—	2	1	9	14
Meningitis, Aseptic	18	11	5	36	37
Mumps	24	8	18	173	358
Rabies in Animals	7	11	7	72	97
Rheumatic Fever	1	—	—	7	7
Rocky Mountain Spotted Fever	20	18	25	70	46
Rubella	—	3	2	82	36
Rubella, Congenital Syndrome	1	—	—	1	1
Rubeola	9	1	26	125	24
Salmonellosis	16	27	18	102	141
Shigellosis	29	13	12	196	88
Syphilis, Infectious (Use Form ODH-228)	6	12	4	48	87
Tetanus	—	—	—	—	—
Tuberculosis, New Active	19	41	37	192	194
Tularemia	1	4	3	6	10
Typhoid Fever	—	1	—	—	1
Whooping Cough	4	4	3	19	12

OSMA Medicare Leaflet Distributed Widely

To My Medicare Patients Your Medicare Benefits Are Being Cut

Your Medicare reimbursement is now being cut drastically! This reduction in Medicare benefits was brought about by the recent application of a 1972 federal law.

Public Law 92-603 instructed the Secretary of Health, Education and Welfare to roll back Medicare payments toward doctor bills to the amounts physicians were charging in 1969 and 1970, plus a small yearly increase to be set by the Secretary.

The Secretary has now ruled that the maximum increase in the Medicare reimbursement for physicians' fees will be only 17.9% over 1970 levels. This unfair reduction in your Medicare benefits is made all the more obvious when you consider that in the same time period the cost of living has increased more than 43%, housing costs have gone up more than 46%, the cost of transportation has increased 34% and food has increased 57%!

Because of this benefit reduction you will begin to see the phrase "more than the allowable charge" appear more often on your Medicare benefit explanation form. Please understand that the "allowable charge" referred to is the reduced amount that Medicare has decided it will pay for your medical care.

In announcing the reimbursement rollback the Secretary of HEW stated that it will save the federal government approximately \$26 million in 1976. What he failed to point out was that this \$26 million will have to be paid out of the pockets of persons on Medicare, the very persons that the program was designed to help.

The Secretary apparently ignored the fact that the Medicare eligible population of this country, those 65 years of age or over, are the ones traditionally living on a limited or fixed income.

If you are concerned, write your Congressman, U.S. Senators and the President of the United States in care of Washington, D. C., to protect your interests.

"Your Medicare Benefits Are Being Cut," is the headline on a leaflet being distributed by all OSMA members to their Medicare patients. The initial supply of 150,000 leaflets was quickly exhausted.

The leaflet, or statement stuffer, was prepared by the OSMA's Public Policy Council and response to new Medicare regulations that will result in a rollback of federal reimbursements to Medicare beneficiaries for physician expenses.

Initially 100 of the leaflets were sent to every OSMA member along with a reorder form. Within two weeks after the first distribution, orders for nearly 100,000 additional leaflets had been received in the OSMA office.

The leaflet was designed to warn Medicare recipients that their reimbursements would be cut because of new regulations being published by the Health, Education and Welfare Department based on a section of Public Law 92-603. That law provided that Medicare car-

riers prevailing charge screens for fiscal year 1973 would serve as the base for measuring all future increases in payments. The charge screens for fiscal year 1973 were based on charge data collected during calendar year 1971. Overlooked, however, was the fact that physicians were in a fee freeze status at that time and their fees were actually those that prevailed in 1969 and 1970.

The net result of the law, combined with the fee freeze, and regulations published by HEW, was to rollback many Medicare reimbursements to the "so-called" 1973 level plus a maximum increase of 17.9 percent over that amount.

Medicare carrier officials have estimated that as high as 80 percent of all physician fee reimbursements will be cutback. □

AMA Files Lawsuit Against HEW Drug Regulations

A lawsuit to block the implementation of new federal drug regulations that would pressure physicians to prescribe low cost drugs for Medicare and Medicaid patients has been filed by the American Medical Association.

The regulations, known as Maximum Allowable Costs (MAC) were approved in final form by HEW Secretary Caspar Weinberger a few days before he left office. Within 24 hours the AMA filed suit in Federal District Court.

While contending the program is the epitome in regulatory control, the AMA referred to MAC as "an impossible labyrinth of drug regulations without assuring a favorable cost-benefit ratio".

The AMA contends the constitutional rights of both patients and physicians would be violated and that the program would produce adversary relationships among physicians, patients, and pharmacists.

The disputed regulations would require pharmacists filling prescriptions for Medicare-Medicaid patients, primarily Medicaid, to be reimbursed on the basis of the lowest cost at which the product is generally available to providers.

Provision was made for a physician to require a higher-priced drug reimbursement if he would state that the drug was "medically necessary." The obvious purpose of the regula-

tions is to stimulate purchase of generic drugs and discouraging purchase of brand names that carry higher costs.

Since there is no substantial outpatient benefit for Medicare, physicians primarily will be affected as they deal with Medicaid patients. In states with anti-substitution laws, a Medicaid prescription for a brand name drug more expensive than the MAC regulations would allow would mean that the patient would have to make up the difference in price unless the physician would be willing to change the prescription to another brand or generic prescription or sign that it was medically necessary.

HEW has predicted that most physicians will go along with a program, estimating that one-half of one percent would use the "medically necessary" route for brand names that exceed the MAC regulation allowables.

The AMA lawsuit argues that the regulations "violate every one of the drug-reimbursement requirements of the Medicare-Medicaid statutes" and defy the law inasmuch as they represent government interference with medical practice by telling physicians which drugs they should prescribe.

Secretary Weinberger estimated the MAC program would save federal and state governments between \$60 and \$75 million a year when it swings into full operation within three to four years.

In addition to the control program, HEW will send all physicians a list of most frequently prescribed drugs along with the prices community pharmacies pay for them. The aim is to encourage physicians to prescribe cheaper products in their regular, private practice.

While no sanctions are provided for physicians, to indicate that their prescription for a brand name is "medically necessary," HEW officials speculated that state health agencies might take a closer look at physicians who do this consistently for all their Medicaid patients. According to HEW officials, the possible penalty by the state would be ouster of the physician from Medicaid participation.

Before a maximum allowable cost can be established for a drug, the Food and Drug Administration must rule out the possibility that there is a bioequivalence problem among its several brands. The HEW Pharmaceutical Reimbursement Board would then propose a MAC at a level equal to the lowest cost at which the drug is generally available to providers.

Before the MAC can officially be established on any drug it must be reviewed by a non-governmental advisory committee and published in the Federal Register for comment.

HEW has stated that one-quarter of commonly prescribed drugs are available for multiple sources. However, the number for which bioequivalence problems can be ruled out is smaller.

The reimbursement that a pharmacist receives for drugs he provides Medicare and Medicaid patients will be based on an estimate of his cost of buying the drug plus a dispensing fee, or on his usual charge to the general public, whichever is the smaller. State Medicaid programs would make the estimates according to price information supplied on a regular basis by HEW.

The MAC regulations as published in final form were somewhat changed from the original proposal. At first it was recommended that exceptions would be made only if physicians certified the drug was the only one effective or that could be tolerated by the particular patient. An FDA official said that this particular

section was changed because of objections from the American Medical Association.

When the regulations were published in the Federal Register over 2,600 comments were filed with HEW. Of that number, less than 300 were favorable. □

DEATH

WILLIAM A LOY, MD
1913-1975

A long-time Pawhuska physician, William A. Loy, MD, died in Oklahoma City, August 8th, 1975. Born in Enid, Oklahoma, Doctor Loy was graduated from the University of Oklahoma College of Medicine in 1937, where he later became a faculty member. Doctor Loy practiced in Pawhuska from 1946 until his retirement in 1972. He had served as District Chairman of the US Medical School Alumni Association.

Doctor Loy was awarded a Life Certificate by the OSMA in 1973. □



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Weinberger Warns About Danger Of Big Government

Caspar W. Weinberger showed a more conservative side when he was on his way out as Secretary of Health, Education and Welfare. While usually cited as a liberal bureaucrat, the last address he delivered as Secretary of HEW was to warn the nation about the dangers of an "all pervasive federal government."

In an address to the Commonwealth Club of San Francisco, the outgoing Secretary made it clear that he is strongly and personally opposed to the growing welfare state. The following are excerpts from his prepared remarks:

"My single overriding observation after these years in Washington is of the growing danger of an all pervasive federal government. Unless checked, that growth may take from us our most precious personal freedoms. It also threatens to shatter the foundations of our economic system.

"We are . . . creating a massive welfare state that has intruded into the lives and personal affairs of our citizens. This intrusion affects both those it seeks to help and those who do the helping. The entire human-resources field is under the lash of federal law — doctor, hospital, teacher, college president, student, voluntary agency, city hall, and state capitol. All of these are subject to the steadily increasing intrusion of the Congress, which requires that drastic and often unnecessary regulations be adopted by the Executive Branch.

"It must be emphasized that this increased intrusiveness is a consequence of legislation not the impulsiveness of the Executive Branch. I had to plead with the Congress to grant a special exemption for Boy Scouts and Girl Scouts from the broad sweep of Title IX the Antisex Discrimination Statute. Yet I venture to say that there is scarcely a person in this audience who does not believe it was all the idea of the Department of Health, Education and Welfare rather than the poorly drafted statute Congress passed, which, unamended, would have required Girl Scout troops to admit boys and vice versa.

"There is an overriding danger inherent to the growth of an American welfare state. The danger simply is that we may undermine our whole economy. If social programs continue growing for the next two decades at the same pace they have in the last two, we will spend more than half of our whole gross national

product (GNP) for domestic social programs alone, by the year 2000.

"Should that day ever come, half of the American people will be working to support the other half. At that point, government would be like a gigantic sponge, sopping up all the nation's surplus capital needed for industrial growth and modernization. Lacking funds for those vital purposes, we would no longer have enough surplus capital left to invest in job reducing activities in the private sector, and it is that kind of investment which has always pulled us out of recessions and depressions in the past. In all likelihood, we could not maintain our free enterprise, incentive capitalistic economy, if 50 percent of the whole group GNP had to be used to pay for domestic social programs alone. And if we lose our free-enterprise, incentive system, we will have destroyed, by inaction, the system that has brought more benefits to more people at home and throughout the world than any other system since recorded history began.

"Those who urge still more social programs view the problem upside down. It is not more social programs that will solve our nation's ills but more economic growth. Growth alone provides the jobs that reduce social ills. Growth alone, provides the revenues that finance our social program commitments, yet one of the most iniquitous of the new philosophies we hear today is the smug assertion that 'less is better and more is worse'.

"What we do have to limit is the growth of the welfare state in America. We must summon up a common determination as a people to change drastically our present approach because it is not only not working, but it can ruin all of us. Only a wave of public sentiment in this direction can give Congress the nerve to say 'no' to more social programs. As it is, Congress quite evidently believes that the road to popularity and reelection is to say 'yes' to every demand for every increase in all existing programs and to agree to most demands for new ones.

"The federal government has been spending more than it has taken in; fifteen of the last sixteen federal budgets have been red ink budgets. If we continue thus, the nation will also stand before the abyss someday, only there will be no one with enough resources to rescue the federal government. This need not be the result. Always before we had the sense, the wisdom and resolution to change course in time." □

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Physicians May Report Medically Impaired Drivers

Physicians now have immunity from legal action if they report patients with health problems that make them potentially dangerous drivers.

In the closing days of the last Legislature, Senate Bill 296 was passed. This bill provides that physicians treating individuals "for any illness or injury that would impair the ability of the individual in any manner as to affect the performance of the person to operate a motor vehicle" may make a written report of the diagnosis to the Department of Public Safety's Drivers License Medical Advisory Committee.

Any physician making such a report, so long as it is done in good faith and without negligence or malice, is granted immunity for civil liability for their acts.

When such a report is received, the Medical Advisory Committee of the Public Safety Department, comprised of seven physicians, reviews the case and makes the recommendations to the department.

Physicians have had the right to report potentially dangerous drivers for many years. However, they seldom did because of the fear of lawsuits. The law, as originally written, did not contain the section providing immunity from civil liability.

R. B. Carl, MD, representing the OSMA, testified to the Legislature that he believed there was a need for such a law for "the relatively few times when a patient is uncooperative, or when, because of his disability or brain lesion, his judgment is such that he cannot be reasoned with."

Leroy Carpenter, MD, State Commissioner of Public Health, and Secretary of the Medical Advisory Committee wrote, "I have seen several hundred cases where a physician has desired to report a driver whose physical condition is detrimental to himself or the safety of others on the highway. However, most physicians are reluctant to report . . . because of potential liability."

Another section of the same law provides that any reports, or the transcripts of proceedings resulting from such reports, shall not be entered in evidence in any other type of hearing, except for the purpose of revocation, suspension, cancellation or denial of an individual's drivers' license. Such records are not to be considered "public record." □

Kelsay To Head PSRO Study

Ed Kelsay has been chosen by the Oklahoma Foundation for Peer Review, Inc., to serve as the Foundation's Executive Director and as Project Director for a Professional Standards Review Organization Planning Contract for the State of Oklahoma. The contract was entered into by the foundation at the direction of the OSMA House of Delegates and Board of Trustees.

The employment of an Executive Director is the first action of the Foundation to fulfill its one-year Planning Contract with HEW.

The new Executive Director is best known to Oklahoma physicians as one of the Associate Executive Directors of the Oklahoma State Medical Association. He is an attorney and is an adjunct professor of Medical Law, Ethics and Economics at the OU Health Sciences Center.

In a recent interview the new Executive Director stated, "It is now obvious to all parties concerned that PSRO, as originally envisioned, was an ill-conceived program that would directly interfere with the practice of medicine and significantly add to the health care costs of the nation. The stated aim of PSRO is to increase the quality and quantity of medical care while restraining costs. It is our desire, in Oklahoma, to formulate a program that will carry out that aim without damaging the quality of care, interfering in the doctor-patient relationship or increasing the costs.

"A perfunctional reading of the original law and the published PSRO regulations would indicate that the Health, Education and Welfare Department felt that the only way the aims could be carried out was by a constant monitoring of physician practice via a bulky bureaucracy followed up by a constant computerized check and double check on all services rendered. We think it's possible to accomplish the stated purpose of PSRO without such physician vexation and bureaucratic expense by relying on continuing education."

During the next year the foundation will be seeking input from every physician in the state to assist it in preparing a plan for presentation to HEW. Hillard E. Denyer, MD, Chairman of the Foundation's Board of Directors stated, "we want our plan to be a 'physicians' plan', based on the principles of good medical practice and not a 'bureaucrats' plan' based on a misconception of the practice of medicine." □

Last Chance For OSMA Hawaii Tour

Oklahoma physicians have one more chance to sign up for the OSMA sponsored tour to Hawaii for the American Medical Association's 1975 Clinical Session.

Although the tour is nearly full, physicians still have an opportunity to select one of two departure dates from Oklahoma City, either November 27th or 28th. Those leaving earlier will pay only \$25 extra for the entire tour. All physicians will return to Oklahoma City on December 7th.

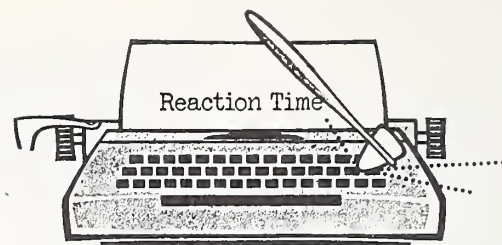
The per person price for the tour is \$589 and includes roundtrip jet airfare from Oklahoma City to Honolulu and return with economy class seating via Braniff 747. The price also includes inter-island airfares. Seven nights superior class accommodations at the Hawaii Regent Hotel in Honolulu and two nights deluxe accommodations at the Maui Surf Hotel in Maui.

The six-day seven-night stay in the Hawaii Regent will give all physicians an opportunity to attend the entire AMA Scientific Meeting, November 30th through December 5th. In addition, the scientific program is being prepared for the two extra days stay on Maui.

An optional two-day tour to the Mauna Kea Beach Hotel on the big island of Hawaii is available in place of the two-day stay on Maui. This particular hotel was developed by Lawrence Rockefeller and has frequently been described as one of the greatest resorts in the world. A \$55 per person additional charge is necessary for the Mauna Kea option.

Most of the American Medical Association's scientific program during the Clinical Convention has been arranged between the hours of 7:15 a.m. and noon each day. This allows Hawaii visitors their afternoons and evenings to enjoy the wonders of Honolulu. Post-graduate topics include hyperlipodemia, pulmonary function tests, newer antibiotics, basic and advanced EKG, dermatology for nondermatologists, peripheral vascular disease, infectious diseases in children, pitfalls of emergency room x-rays, and many, many others.

Anyone wishing to participate in the ten-day tour should contact the OSMA office by telephone immediately. Area Code 405-842-3361. ☐



Arnold G. Nelson, MD
President
Oklahoma State Medical Association
601 N.W. Expressway
Oklahoma City, Oklahoma 73118

Dear Doctor Nelson:

Please convey to the Board of Directors and membership of the Oklahoma State Medical Association my most grateful thanks for their efforts in connection with our Health Professions Student Loans. The check just received in the amount of \$2,735 brings the total OSMA contributions to \$11,000. On a one-ninth matching basis these contributions have enabled the College of Medicine to secure \$99,000 in federal loan funds over the past three years. The following points are important and you may wish to convey them to your members:

1. All of the funds are *loaned* to medical students with the eventual repayment of those funds being reloaned on a revolving basis to other students. In effect, then, the real worth of the contributions can be measured in terms of the number of loans made from a perpetual revolving account over an indefinite period.

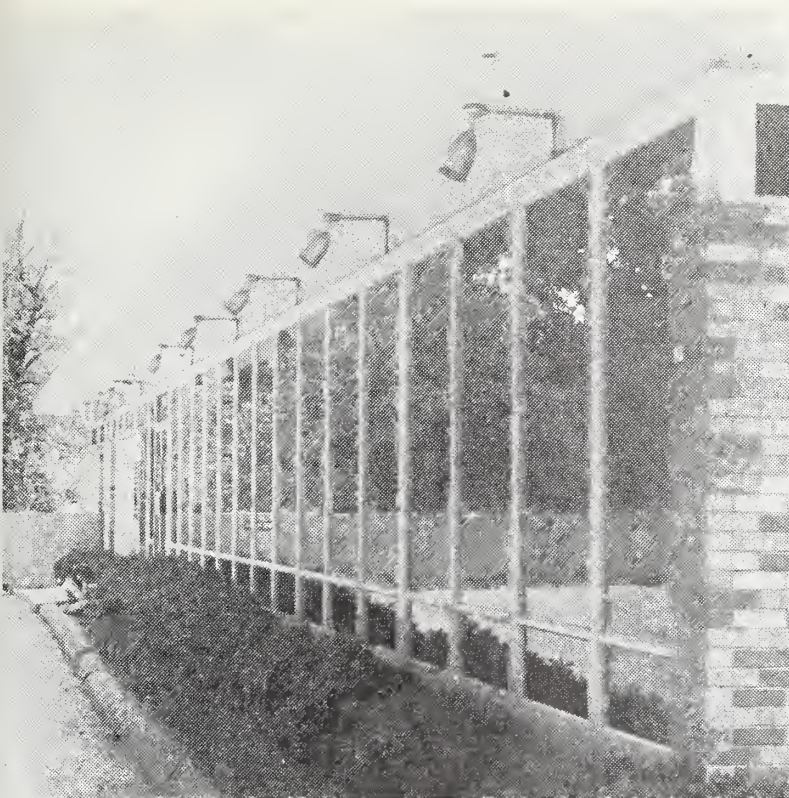
2. Added to the \$11,000 contributed by the OSMA the total amount made available was \$110,000.00.

3. Our Regional Office informs us that any new legislation will *not* contain appropriations for Health Professions Scholarships, which means that unless a student wishes to negotiate a return service contract, he must borrow the full amount of his need each year.

You can see how tremendously important this program is to the students in the College of Medicine and why we are so appreciative of your efforts.

Best regards.

Sincerely,
Thomas N. Lynn,
MD
Acting Dean



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Three New Tours Available To OSMA Members

1976 will be an international travel year for OSMA. The association has contracted for three tours to be made available to its members.

All three of the tours will be conducted by INTRAV, one of the nation's largest group travel organizations.

The first 1976 tour will be a nine-day eight-night, land tour of Central America known as the "Mayan Adventure." This tour will depart from Oklahoma City on January 7th and will be co-sponsored by the Rocky Mountain Medical Group, medical doctors from the Colorado-Utah area.

A second tour is set for July, with the exact departure date to be chosen later. It's a two-week tour to the Far East, including stops in Singapore, Hong Kong and Bali. It is possible that the Oklahoma Bar Association will co-sponsor this tour with the OSMA.

The third tour for 1976 will be a two-week air-sea cruise of the Mediterranean on the new ship "Daphne." The OSMA has asked for an October departure on this trip, but on a date that will not conflict with the OU-Texas football weekend. Joining the OSMA as co-sponsors on this trip will be the Michigan Medical Society, the Sedgwick County Medical Society (Kansas) and the Alumni Association of the University of Arizona.

Additional information on each of the three tours will be distributed to all OSMA members several months before each departure.

The first tour, the Mayan Adventure, will be a nine-day, eight-night, air-land tour of Central America. Price will be \$649 per person.

Travelers will depart Oklahoma City and will fly directly to San Salvador and will spend four days in the beautiful Hotel Camino Real. For sun worshipers the beach and the surf on the Pacific are hard to beat, but the hotel also has an inviting swimming pool with flower-decked patio. For the more adventuresome, there will be visits to the Mayan Ruins of the ancient city of Tazumal, a view of the volcanic Izalco and perhaps a visit to the beautiful paradise of quiet pools and exotic flowers, Los Charros.

From San Salvador it's only a short flight to Guatemala City for four more days in another beautiful hotel by the same name, Hotel

Camino Real. The hotel features a beautiful swimming pool, an elegant la Ronda supper club, the El Jaguar Bar and one of the best botiques in the city. Tennis courts and a golf course are nearby.

From Guatemala City, there is an optional excursion to the 9th Century Mayan Ceremonial Center of Tikal. Here the traveler will see the ornate Temple of the Masks and the imposing 21 story high Temple of the Giant Jaguar.

No one should miss a side trip to Antigua, the colonial capitol of Guatemala. The city is a monument to the past with fountains, villas, and ancient cypress trees. A visit to the city is a return to the 17th Century.

Another optional side tour, and one not to miss, is a trip to the Spanish village of Chichicastenango. On market day the pure blooded Quiche Indians, direct descendents of the Mayan's, come from the surrounding hills to barter and to worship both Christian and Pagan Gods at the Church of Santo Tomas.

A full schedule of scientific courses being arranged for the Mayan Adventure.

Additional information on the adventure will be forwarded to all OSMA members in the near future. □

Immunization Action Month Set For October

October is Immunization Action Month in Oklahoma. Purpose of the special month is to locate and immunize susceptible persons to childhood diseases such as measles, rubella, polio, diphtheria, tetanus, and pertussis.

A major promotional campaign is being scheduled for October by the Oklahoma State Department of Health and the Center for Disease Control.

Physicians throughout the state will be encouraged to initiate a working audit of patients immunization records. Each time a record is pulled, for any reason, the vaccination status of the patient should be determined. A special notation should be made if it is determined that the patient is susceptible to the diseases in question.

At the same time, parents will be encouraged to perform their own vaccination audit of their children. If there are any questions parents will be asked to contact their family physicians or public health officers for aid.

During the past ten years health officers have noted that the immunization level has been decreasing slowly, although it fluctuates

from year to year. As an example, in 1965, 84 percent of Oklahoma's pre-school children had been vaccinated for polio. Ten years later, only 71 percent had been so vaccinated. During the same period, the percentage vaccinated for measles dropped to 70 percent, for rubella to 77 percent, for mumps to 35 percent, and for diphtheria, tetanus, and pertussis to 76 percent.

The result of this drop in immunization level is that these preventable diseases, once thought to have been brought under control, are now reappearing. The greatest danger is to pre-school children. Oklahoma, like many other states, has a law that says that a child may not enter school in this state for the first time unless he has received certain immunizations. Many parents wait until the child is ready to enter school before either complete, or in some instances, even start, the child's immunization program.

Public health experts have speculated that the reason so many children go unvaccinated is that people no longer fear the diseases, they consider them to be a thing of the past. It is estimated that nearly 40,000 Oklahoma children between the ages of one and four years are either unimmunized or inadequately im-

munized against the so-called childhood diseases.

The immunization levels differ from county to county in Oklahoma. Using polio as an example, the percent of preschool children fully protected against polio ranges from only 50.4 percent in Adair County to 84.1 percent in Texas County. Measles immunization is lowest in Delaware County with a 54.9 percent level and highest in Seminole County with 87.2 percent.

Immunization levels for rubella are the highest everywhere with a statewide average of 76.9 percent. Only one county, Cherokee, has an immunization level less than 60 percent for rubella, with 59.6 percent. The highest rubella immunization level is in Love County with 87.4 percent of preschool children fully protected.

Immunization Action Month is now in its third year. It is a cooperative effort sponsored by the Oklahoma State Health Department, the Oklahoma State Medical Association, government, industry and volunteer organizations. Although last year's immunization level increase was small, it did mark the beginning of an upward trend. □

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Inter-American Symposium On Internal Medicine Will Convene In Mexico

The Department of Medicine, University of Oklahoma Health Sciences Center in association with the National Academy of Medicine of Mexico will sponsor the first annual Inter-American Symposium on Internal Medicine in Mexico City next January. The meeting will convene at the Centro Medico of the Instituto Mexicano Del Seguro Social, January 12th to 15th, 1976.

Theme for the course will be "What's New In Diagnosis and Therapy" offering a thorough update on trends in internal medicine. Subject material will feature discussion in gastroenterology, cardiovascular, renal, pulmonary, hematology-oncology, endocrinology and infectious diseases. The Inter-American nature is realized by the participation of well-known and respected educators from Mexico and Canada, complementing a superb faculty from the University of Oklahoma.

Group air fares will be available from a

choice of US cities, as well as a package of fine hotel accommodations, sightseeing and meals during the stay in Mexico City. Plans are being made to bring the participants and their wives to Mexico on Saturday, January 10th for leisure time before the symposium activities begin. For those wishing to stay on for a few days after the meeting, there will be a choice of three post-symposium tours covering various points of interest in Mexico.

Further details may be obtained by writing James F. Hammarsten, MD, and Solomon Papper, MD, co-directors, The University of Oklahoma Health Sciences Center, College of Medicine, Department of Medicine, P.O. Box 26901, Oklahoma City, Oklahoma 73190. □

ANNUAL SCIENTIFIC MEETING

of the

OKLAHOMA RHEUMATISM SOCIETY

October 11th, 1975

Shangri La Lodge

Afton, Oklahoma

Principal Guest Speaker will be Eric Hurd, MD, Associate Professor of Medicine, Southwest Medical School, Dallas, Texas. His topic will be "Extra Manifestations in Rheumatic Diseases."

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Oklahoma Trauma Society Will Hold September Symposium

The Oklahoma Trauma Research Society will present its annual symposium for emergency medical professionals, "AREMSYS V" in Tulsa, September 10th, 11th and 12th. The meeting will be co-sponsored by the Oklahoma Committee on Trauma of the American College of Surgeons, the Oklahoma Chapter of the American College of Emergency Physicians, and the Oklahoma Chapter of the Emergency Department Nurses Association.

The physicians' seminar will present topics of interest to both the rural and urban physician involved with emergency medicine on a full or part-time basis.

The faculty of specialty physicians will present sessions on air-way management; assessment and management of the shock patient; head, neck and spinal cord injuries; facial injuries; cardiac emergencies, and many other pertinent topics.

The curriculum has been submitted for credit to the American College of Emergency Physicians, the AMA's Physician Recognition Award, and the American Academy of Family Practice.

Registration for physicians is \$75. For complete details, contact the Oklahoma Trauma Research Society, Suite 811, 6465 South Yale, Tulsa 74136. □

Miscellaneous Advertisements

WELL-TRAINED INTERNAL MEDICINE specialist needed immediately for medium-sized Oklahoma city with outstanding hospital facilities and full range of specialty care. Existing practice nets \$60,000 a year. Contact Key W, *The Journal*, Oklahoma State Medical Association, 601 NW Expressway, Oklahoma City, Oklahoma 73118.

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FOR SALE: NEW TEN ROOM CLINIC; two doctors. Fully equipped, 200 M.A. x-ray, lab, E.C.G. Large waiting room, concrete parking lot. Hospital privileges. Henryetta. Reason for sale, returning for residency training. Contact Key H, *The Journal*, Oklahoma State Medical Association, 601 N.W. Expressway, Oklahoma City, Oklahoma 73118.

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EMERGENCY PHYSICIANS: \$50,000 - \$60,000 minimum for new grads or second career physicians. Serve community hospitals in Texas cities of 156,000 - 974,000. All fees paid by hospital. Send C.V. Call collect and in confidence to Toni Clark 512 349-2651. Daniel Stern and Associates, Health Placement Services, Suite 510 GPM Tower, San Antonio, Texas 78216. □

Summer Report of the President

The 1975-76 year for the OSMA Auxiliary began in April with a well attended post-convention board meeting. In June Mrs. William B. Renfrow, Mrs. James Haddock, Mrs. Orange Welborn, Mrs. Joe Crosthwait and Mrs. Ed Calhoon, delegates, and Mrs. John McIntyre, alternate, attended the national convention in Atlantic City.

Doctor Malcom Todd, AMA president, gave the keynote address. He urged auxiliary members to become involved in an educational campaign to gain public support for the legislation most beneficial to the health care of the country.

Another speaker, Mary Louise Smith, Republican National Committee chairman and an auxiliary member from Iowa, spoke on the government's role in terms of health care and what we, as doctors' wives, should be doing about it. Mrs. Smith said, "Restraint of government, protection of personal freedom, adherence of traditional American values — all these come as a result of raised voices. They are a response to those who work to make the system better," she added, "and they are too important to leave to someone else. Besides, if you do not care enough about your beliefs to stand up and fight for them . . . can you honestly expect anyone else to do it for you?"

The national president, Mrs. Howard Liljestrand, presented Doctor John Budd, Vice-President of the AMA Education and Research Foundation, a check in the amount of \$1,361,564.21. Of this amount, Oklahoma had contributed over \$21,000.00. An award was presented to the Oklahoma auxiliary for contributing \$16.50 per member. This is the time to say "well done" to the almost 1,300 state members.

Important changes were made during the House of Delegates Meeting, including a change of name to American Medical Associa-

tion Auxiliary, in keeping with the policy of accepting both husbands and wives of physicians as members. (Oklahoma has not had this bylaws change as yet.) The house of delegates voted a \$3.00 increase in dues, bringing national dues from \$4.00 to \$7.00. This will go into effect June, 1976. Also, bylaws changed to meet current demands of economy and programming.

Mrs. Erle E. Wilkinson was installed as our new national president. In her inaugural address Mrs. Wilkinson called for unity of goals and purpose. She said this is vital "if we, who are concerned with medicine's and our husbands' futures, are going to move forward and face the problems and challenges before us." She asked for more communication of a positive attitude. We need to be better informed, she said, but better yet, we need to get through, to our members, to other doctors' wives, to the community.

I would be remiss if I did not mention a new program concept from the national auxiliary that is being implemented this year — the Project Bank. This consists of catalogued information, kept at national headquarters, containing projects from county and state auxiliaries, and programs obtained from health-related organizations. When a county needs information on a project or program they have access to the "Knowhow" from all 50 states.

This plan offers a communication system through which auxiliaries across the country can share information on projects that have worked successfully for other auxiliaries in their communities.

A summer board meeting was held August 4th in the home of the president. In conjunction with this, mini-workshops were held on Legislation, AMA-ERF, Community Health and Health Education. A workshop was also held for the county presidents, councilors and councilors-elect on membership. *Loretta Renfrow* □

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The JOURNAL

of the Oklahoma State Medical Association

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January Issue

Editorial, Scientific, Book Reviews November 15, 1975

Advertising Copy

December 12, 1975

News Copy, Miscellaneous

December 10, 1975

CONTRIBUTIONS

Articles accepted for publication, including manuscripts of annual meeting papers, are the sole property of *The Journal* and must not have been published elsewhere. Authority for approval of all contributions rests with the Editorial Board, and the Board reserves the right to edit any material submitted. Manuscripts should be typewritten, double spaced and submitted in original and one copy. Receipt of manuscripts will be acknowledged and unused manuscripts returned. Used manuscripts will be returned on request. *The Journal of the Oklahoma State Medical Association* is not responsible for the statements or opinions of any contributor.

STYLE

Footnotes, bibliographies, and legends for illustrations should be submitted on separate sheets, double-spaced. Bibliographies should follow in order of: name of author, title or article, name of periodical with volume number, page and date of publication. These references should be alphabetized and numbered in sequence.

ILLUSTRATIONS

Illustrations, other than the author's will not be accepted for publication unless accompanied by written permission to be reproduced. Illustrations should be identified by the author's name and the figure number of the illustrations. The illustrations should be numbered in the same order as referred to in the body of the article. Used photographs, and drawings will be returned after publication if requested. *The Journal* will pay for necessary black and white illustrations within reasonable limitations. The quality of drawings, sketches, etc., must be in keeping with the quality of the magazine.

NEWS

Members of the Oklahoma State Medical Association, the constituent societies of the association, and all readers in general are invited to supply news items of general interest to the profession.

ADVERTISING

All advertising copy must be approved by the Editorial Board before acceptance for publication. General and miscellaneous advertising rates will be sent on request.

EDITING SERVICE

The Editorial Board reserves the prerogative to submit contributions to a Medical Editing Service when warranted. If such is felt necessary, the Editor will contact the author for approval, informing him that there will be a modest charge for this service.

REPRINTS

Authors will receive reprint order forms from the Transcript Press, P.O. Drawer 1058, Norman, Oklahoma 73069, prior to final publication of their articles. Other requests for reprints must be made to the Transcript Press within 30 days after publication.

BACK ISSUES

Microfilm copies of back issues of *The Journal* may now be purchased from University Microfilms, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

Mathews is in, Weinberger is out. Caspar Weinberger has been replaced as Secretary of HEW by F. David Mathews. The new secretary is a 39-year-old PhD who has served as President of the University of Alabama since 1969. He was confirmed by the Senate as the new HEW Secretary on July 22nd. In testimony on his nomination before the Senate Labor and Public Welfare Committee, Mathews said he is particularly sensitive to the problems of rural care and predicted clinics rather than hospitals will be needed to serve remote areas.

"Trustworthiness," physicians lead the pack. In a survey by the Chilton Research Service, persons were asked to rank various professions as to trustworthiness on a scale of one to ten. Physicians led all occupational groups, scoring 8.2. Bankers were second with a score of 7.9, professors scored 7.3, news reporters 5.8, and politicians were low on the scale with 3.7.

Old liberals or new conservatives? One of the questions going around Washington is just what is happening to the old liberals. Wilbur Cohen, former HEW Secretary, now dean of the University of Michigan School of Education has urged Congress to go very slowly on acting on any national health insurance. He testified that swift action on the issue would be "a tragic mistake" for "so monumental an undertaking." Another former HEW Secretary, Caspar Weinberger, revealed his more conservative side in a California speech reported on page 363 in this issue of *The Journal*. Oklahoma's share of the federal tax burden is 1.05 percent of the total. The US Chamber of Commerce prepared an informative table which enables taxpayers to estimate the tax burden placed on their states by federal spending programs. The state of California is highest with 10.80 percent of the total, New York is second with 9.95 percent, and Wyoming is lowest with .16 percent.

Senator James Allen, a Democrat from Alabama, came up with the following: A recent Office of Management and Budget Survey on the number of reports required at business-

es — just from certain federal agencies — shows that 2,178 different types of reports are required and that it took business men the equivalent of 35.6 million — that's million — man-hours to fill them out. And the trend is definitely up.

Social Security Administration's actuaries are getting worried. They now report that unemployment and inflation are throwing the retirement system into deficit sooner than they had earlier forecast. Outlays will exceed receipts this year by \$2.5 billion leaving reserves at \$43.4 billion and by 1980 only \$800 million will be left in reserves — not enough to cover one week's benefits.

It's not all thankless! Recently OSMA President Arnold G. Nelson, MD, appeared on a local television program in Oklahoma City. After his appearance an attorney, Toney M. Webber, with the firm of Howell, Webber & Sharpe, in Midwest City, took time to write and say that although he did not get to see the entire show, ". . . I heard enough to make me proud to be an Oklahoman." Mr. Webber's partner, James Howell, is a State Senator from Doctor Nelson's district. □

AMA TULSA REGIONAL MEETING

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- Dermatology for the Non-Dermatologist
- Cardiac Arrhythmias
- Management of the Critically Injured
- Acid-Base, Fluid and Electrolyte Balance

The charge for registrants will be \$10 per credit hour, *ie*, six-hour course will be \$60. Course faculty will be selected from the Oklahoma Medical Schools in Tulsa and Oklahoma City.

The JOURNAL

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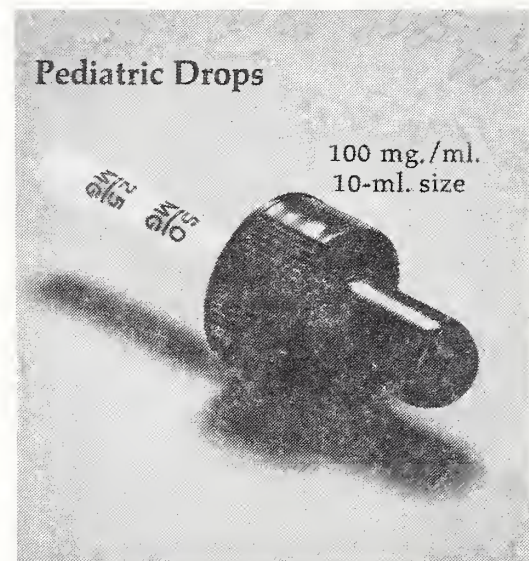
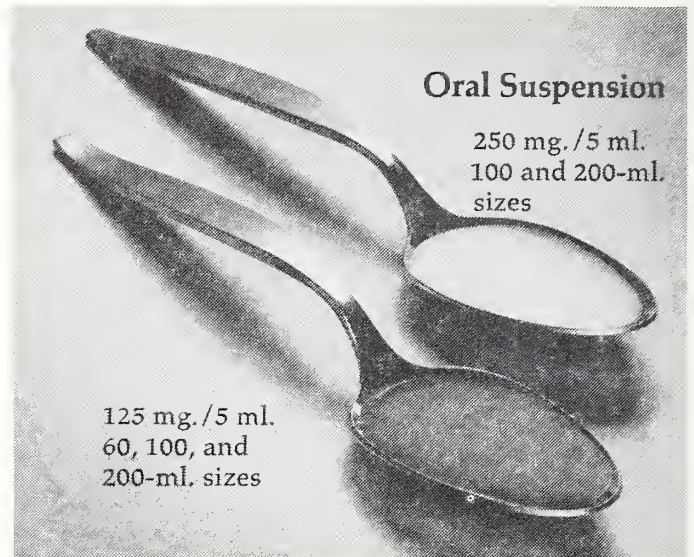
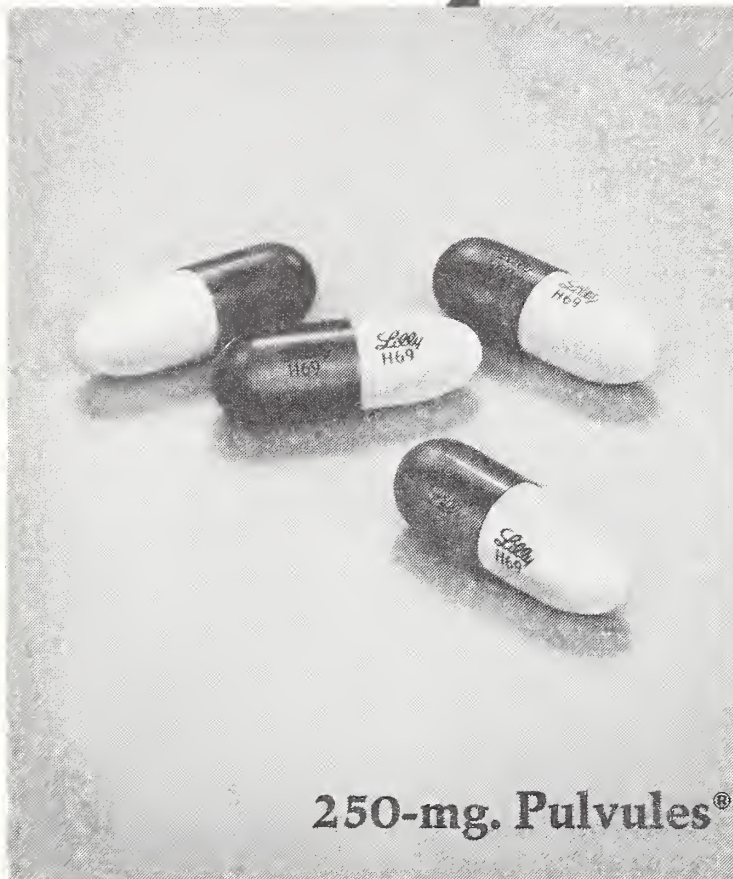
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On the Trail of the Tricky Thyroid

Primary hypothyroidism is a unique endocrinologic disorder. Likely it is the most often empirically treated endocrine ailment in the absence of bona fide evidence of dysfunction and commonly, it is an overlooked but potentially serious disease. Recent advances in laboratory methodology have greatly facilitated the recognition of hypothyroidism and automated chemical screening has uncovered heretofore unexpected abnormalities which can serve as important clues in detecting decreased thyroid function.

The advances in thyroid methodology are principally in the ability to measure the hormones involved in normal and abnormal thyroid function by specific and sensitive assay systems. These hormones are thyroid stimulating hormone (TSH), thyroxine (T4) and triiodothyronine (T3). The relationship between the thyroid hormones (T3 and T4), and TSH is an example of classic "negative feedback" control. Elevation of the biologically active ("free") thyroid hormone concentration results in less TSH secretion. Subnormal levels of thyroid hormone are associated with elevated TSH secretion.¹ In addition, the T3 resin uptake (T3RU), a test detecting the saturability of the prime transporter of thyroxine, ie thyroxine binding globulin (TBG), permits the recognition of alterations in total thyroxine concentration not due to abnormal thyroid function *per se*, but due rather to changes in the concentration of the transporting protein, TBG. Fortunately, the mathematical integration of the degree of TBG saturation (T3RU) and the total thyroxine (T4) correlates well with the actual "free" thyroxine and serves as a good index of true thyroid function. These mathematically integrated values may be called thyroxine-resin T3 index (T3RU x T4 concentration) or "adjusted thyroxine" (T3RU of patient/T3RU of normal x thyroxine concentration). The information gained is the same, but the American Thyroid Association recommends that the former name be used.

Certainly, terms such as T7 are meaningless jargon and should be avoided.²

Hypothyroidism may be far advanced and obvious, or as many clinicians know, it may also be subtle and difficult to define. Today, however, instead of bedside cogitation and empiric therapeutic trials, the new laboratory methods have removed the blinders from these subtle expressions of hypothyroidism and allow the physician to carefully document thyroid dysfunction. Primary thyroid hypofunction can be detected even when the circulating levels of thyroid hormones are "within normal limits," because it is the individual's own control mechanisms that define euthyroidism as opposed to hypothyroidism. For example, a low normal thyroxine or thyroxine-resin T3 index, if associated with elevated TSH levels, is hypothyroidism and should be so approached therapeutically. Additionally, the findings of an elevated TSH concentration in the face of a definitely low thyroxine level removes all doubt as to a central or pituitary cause of hypothyroidism and pinpoints the disorder to the thyroid gland itself.

Automated biochemical analyses of blood specimens have identified several changes commonly seen in hypothyroidism which may not be widely appreciated. Certainly, elevations of cholesterol have long been associated with hypothyroidism, but striking elevations of serum creatine phosphokinase (CPK), SGOT and LDH enzymes have been relatively recently noticed. The CPK determination, particularly, may be dramatically elevated in hypothyroidism and can thus serve as a clue to the underlying disorder.³ The alterations of SGOT and LDH are seen with less regularity. The presence of these enzymes in the blood can probably be traced to "leaks" in the hypothyroid skeletal muscle cell membrane.⁴ Local experience in both in- and outpatient practice is

(Continued on Page 399)

Professional Liability Study Commission

The Board of Trustees of the Oklahoma State Medical Association approved the formation of a new committee called the "Professional Liability Study Commission." The purpose of this committee is to formulate a two or three year game plan designed to bolster our position, and thus prevent the favorable Oklahoma Professional Liability situation from deteriorating.



Even though Oklahoma has the best statewide Insurance Program in the Nation, complacency will not ensure our number one position. In fact, unless we take steps beginning now, it is virtually assured that we cannot continue to buck an adverse national trend for any length of time in the professional liability insurance field.

To successfully solve the problems that we may be faced with in Professional Liability Insurance, I have named a very strong Committee whose brain power is equal to the task before them. Serving on this Study Commission are the following:

C. Alton Brown, MD, Chairman: Doctor Brown has served as the Chairman of the OSMA Council on Insurance for a number of years, and therefore, I feel that he has a very appropriate background for this Study Commission.

Barton Carl, MD: Chairman of the OSMA Legislative Committee. Doctor Carl has very effectively served our Oklahoma Legislative Committee for many years and is therefore essential to the Study Commission.

Floyd Miller, MD: Doctor Miller is representing the American College of Physicians, and is a Past-President of the Tulsa County Medical Society.

Leroy Long, MD: Doctor Long is representing the American College of Surgeons.

William G. Bernhardt, MD: Doctor Bernhardt is representing the Oklahoma Academy

of Family Physicians. He has served on the Association's Insurance Council and the Legislative Committee for several years.

Jack Spencer, MD: Doctor Spencer is representing the Oklahoma County Medical Society.

George Kamp, MD: Doctor Kamp is representing the Tulsa County Medical Society.

Ex-Officio Members of the Study Commission will be:

Roy Lytle, Attorney: Mr. Lytle is the OSMA General Counsel.

George Short, Attorney: Mr. Short is one of our defense attorneys in the Oklahoma City office.

Joe Glass, Attorney: Mr. Glass is one of our defense attorneys in the Tulsa office.

Tom Haynes: Mr. Haynes is the able Claims Manager of the Insurance Company of North America.

Rod Frates: Our general insurance agent, Mr. Frates manages what we believe to be the best statewide insurance program in this nation.

This Study Commission will, no doubt, make many recommendations. Legislative reform will, of course, be of primary interest; but we should not limit our activities to that area. Doctor Barton Carl will tell us that there are practical political deterrents against any expectations we have that total security can be found through legislative relief. We must prevent malpractice claims from occurring with increasing frequency, and the association has a role to play in making its members better clinicians and in making certain that our association members become intimately acquainted with the legal responsibilities they have to their patients.

It seems even more important, regardless of the malpractice consequences, that the time has come to reassess how we treat our patients as sensitive human beings whose lives have been interrupted with unwanted and unexpected illnesses. This Study Commission will undoubtedly want to receive testimony from special interest groups within our own ranks and with our various members who have expertise in the various fields of medicine. The Commission, no doubt, will discuss our concerns with lawyer groups, and certainly will need to make contact with the leaders of the Legislature. It will also be important to discuss the important issues with the members of the Executive Branch of our State Government.

(Continued on Page 395)

Xeromammography in Private Practice

RALF E. TAUPMANN, MD
WILLIAM R. ALBRACHT, MD
GARY G. ROBERTS, MD
JAMES T. BOGGS, MD

Xeromammography appears to offer one of the better methods for early detection of breast cancer.

Twelve hundred xeromammograms were performed in a period from 1 Jan 74 to 31 Oct 74. Two months were allowed for biopsy reports to accumulate. The following is a discussion of our experience with this number of xerograms. The four authors had similar special xerographic training, making terminology of interpretation easier to standardize and tabulate.

Medical interest was first given the xeroradiographic process in the mid 1950's by Roach and Hilliboe¹ and also by Campbell et al.² Gould et al³ and Rusika⁴ explored the xeroradiographic capabilities in the early 1960's. The process was actively revised in the mid 1960's by John Wolfe⁵ of Detroit and John Martin⁶ of Houston. This was accomplished as a joint effort by the Xerox Corporation and the

American College of Radiology Breast Cancer Task Force.

The xerographic process utilizes a special aluminum plate coated with a thin layer of selenium, a semi-conductor, which is positively charged before use. The plate is housed in a light-tight cassette. Conventional x-ray of low kilovoltage is used to make the exposure. A positively charged latent image is now on the xerographic plate. This image is then developed by exposing it to an oppositely charged powder and transferred to a special paper for permanent viewing and storage.

The advantages of the xerographic process are the rapidity with which the image can be obtained, the elimination of a dark-room, a decrease in the radiation exposure to the patient and, probably most important, a tremendous increase in fine detail, which the xerographic process has. This has enabled the viewer to pick up occult carcinomas more often, as well as to appreciate subtle changes in the ductal pattern which heretofore were less possible with conventional x-ray techniques. Fine tumor calcifications previously missed on conventional radiographs are much more striking on the xeroradiographs.

The standard craniocaudad, lateral and axillary views were obtained and mounted in a mirror image fashion (Figure 1) and then compared for changes in ductal patterns, skin thickening, tumor calcifications, soft tissue masses with indistinct borders, or masses that have no obvious "mates" on the opposite image. Attention also was paid to changes in venous-diameter ratio.⁷ On many occasions, these xeroradiographs were read by more than one radiologist.



Figure 1: Standard Cranio-caudad view mounted in "mirror image" fashion. This facilitates comparison of areas of interest.

DISCUSSION

Twelve hundred xeroradiographs were performed in the previously mentioned period of time. Data collected, such as age, parity, history of previous cancer in the patient, and mammary cancer on the maternal side, were recorded. Previous history of breast exam, such as x-ray mammograms,

eromammograms or thermograms, was also recorded. Prior biopsies were drawn on a breast diagram. (Table 1) Two months were allowed for as many biopsies as possible to be performed and for the pathologic data to accumulate. Of the 1,200 exams, 146 biopsies were performed. Of these 146 biopsies, 124 specimens were from benign tissue; 22 specimens were from malignant tissue. (See diagram for age distribution on Table 2) These statistics correlate relatively well with those of Martin⁸ and Wolfe⁹ but fall below those of Frankel.¹⁰

Of the 22 malignancies there were two originally interpreted as benign tumors. On one of these "false negatives," a mass was described, but because of its smooth borders it was called *probably* benign. This turned out be a "knobby" carcinoma. The other was missed completely. Ninety-three per cent were correctly diagnosed and 10% of these were occult. We deemed a lesion occult when it was found de-novo, in a location where the referring physician did not palpate it or in the opposite breast. It is of note that two of the malignancies were in patients who had metastases from sites other than the breast. One was carcinoma of the lung with metastasis to a high lymph node in the breast; the other was an adenocarcinoma from an undetermined site with the patient also having subcutaneous nodules on her back below the scapular margin and several lesions within both lung fields.

Of the 124 biopsied benign tumors, 106 were diagnosed correctly and 18 "false positives" were diagnosed. The 18 false positives fell into

PHYSICAL EXAMINATION: DIAGRAM MASSES, PREVIOUS SURGERY SITES, SKIN AND NIPPLE ABNORMALITIES, MOLES, AND WARTS.

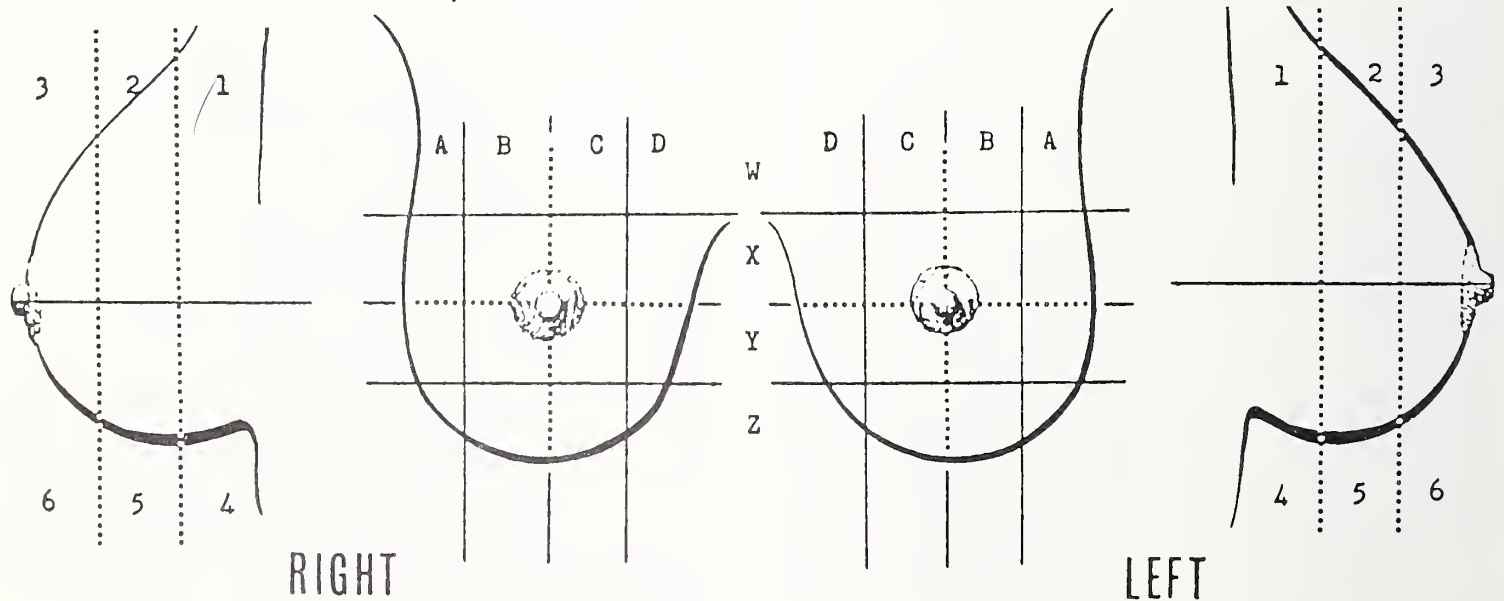


TABLE I

Breakdown by age of 146 Biopsies

Age	30 and below	30-40	40-50	50-60	60-70	70-80	80 and above	Total
Benign	15	17	45	27	12	7	1	124
Malignant	—	1	6	3	4	6	2	22
Total 146								

TABLE 2

a category which were called *suspicious* on the xerogram report. Either biopsy or re-examination in three to six months was suggested. Thirty-six biopsies were performed on the basis of a diagnosis of a benign tumor, a suspicious mass on palpation being the probable criterion. These patients were all above 35 years of age.

The authors tried to adhere to three main diagnoses. If the lesions had characteristics of malignancies and were well-documented they were called malignant and biopsy was strongly recommended. A second category, rather small in number, showed a suspicious "mass" effect which had certain features suggesting carcinoma; biopsy or re-study in three to six months was suggested. Lesions of the third category were called benign. As with all x-ray and xerographic examinations, the history and the location of palpated masses were extremely important in the classification of lesions.

From our breast questionnaire, it is interesting to note that 467 women reported finding a lump on self-examination and sought further

help from their physician. Four hundred seventy-four women had lumps palpated by their physicians on routine physical examinations. Specifically, 14 patients had a positive or suspicious thermogram. Seventy-five patients were follow-up patients for routine xeromammograms following breast cancer surgery on the opposite breast. Seven patients had "baseline" xeromammograms prior to augmentation mammoplasty. A small number of patients were concerned and just wanted the study performed. The remaining 163 patients gave no particular reason that could be ascertained from our questionnaire for having the exam. Some patients, although urged to fill out the questionnaire completely, chose not to do so.

Another interesting fact is the time which had elapsed between the discovery of the lump

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A graduate of the University of Louisville School of Medicine, Gary G. Roberts, MD, has been certified by the American Board of Radiology. He is affiliated with the American College of Radiology.

A University of Oklahoma College of Medicine graduate, James T. Boggs, MD, is certified by the American Board of Radiology. Among his medical affiliations are the American College of Radiology, the Oklahoma State Radiology Society and the Greater Oklahoma City Radiology Society.

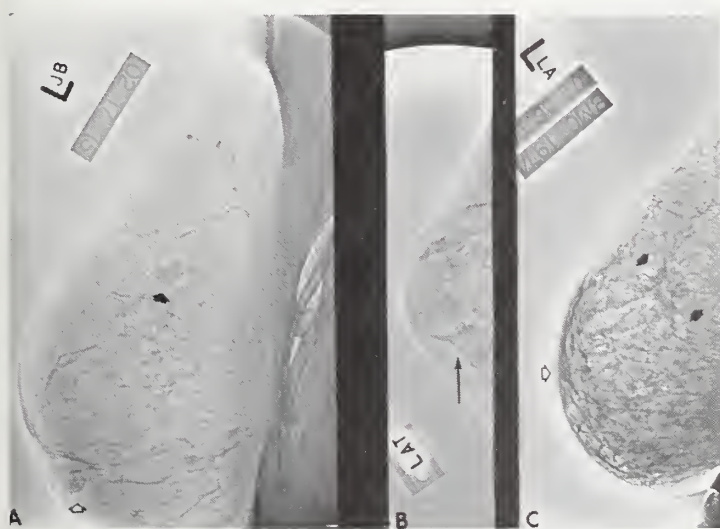


Figure 2: A. Colloid Carcinoma of Breast (closed arrow). Mole on skin (open arrow). Note this could easily be mistaken for a tumor.

B. Infiltrating duct carcinoma. Note fine sand-like calcifications (long arrow).

C. Note rather marked skin thickening (open arrow). Patient has infiltrating duct carcinoma (closed arrows).

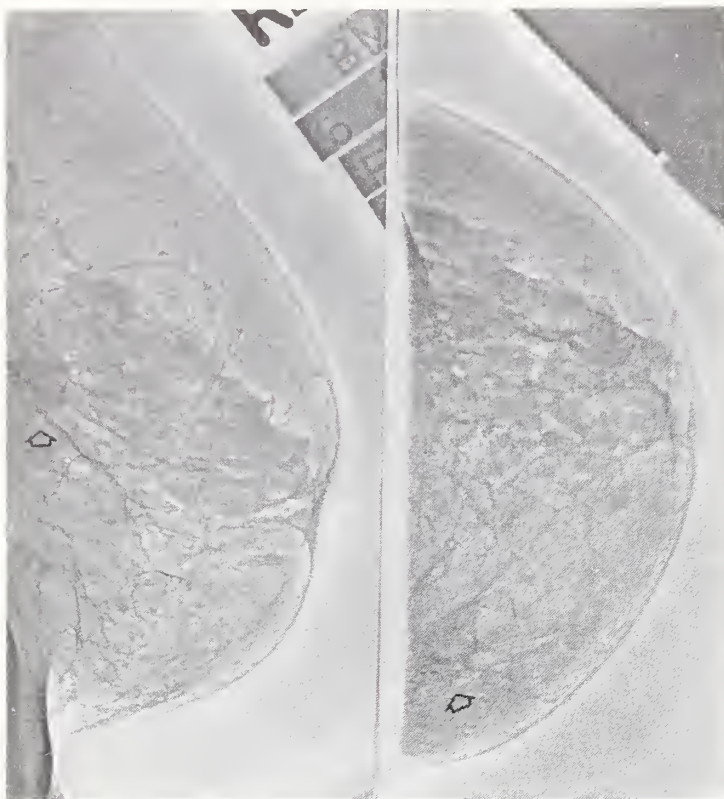


Figure 3: Patient shows a large intra ductal CA (see open arrow) with calcifications scattered throughout.

or the suspicious lesion and medical help was sought or a xeromammogram was requested. This varied from a few days or weeks to several months. Seven patients waited a year or more until seeking further medical attention for their "breast lump." Curiously enough, three of these had carcinoma.

We also found it important to have a competent technologist performing the actual xerographic examination. Proper positioning is a must for good reproduction of the bilateral "mirror" image. Radiographic settings (ie KVP and MAS) also are critical, and a well-trained technician can adjust these according to the size and consistency of the breast of the patient. The appropriate adjustment can be made quickly after viewing the first xerographic image.

Mention also should be made that in our experience certain lesions or masses palpated by the referring clinician sometimes were not imaged on the xeroradiographs, and conversely, imaged masses sometimes could not be palpated by the referring physicians, even though these appeared quite large (2-3cm) on the xerogram.

In our experience we have also found that cooperation among the referring physician, the radiologist and the pathologist is vital because

smaller tumors are now being detected by xeromammography. This makes sectioning and localization of these tumors more difficult for the pathologist. Specimen xeroradiography has been extremely helpful in localizing these small tumors for frozen-sectioning as well as for the preparation of permanent slides. This is done with relative ease while the patient is still under anesthesia, thus saving the patient a possible second trip to the operating room and a second anesthetic.

CONCLUSION

It appears that xeromammography has definitely established its place in the detection and diagnosis of lesions of the breast. This is not to suggest that a thorough manual examination should be omitted, but should be supplemented with xerograms. Patients in high-risk groups and patients with previous mastectomies especially benefit from periodic examinations. The advantages over conventional x-ray examinations are evident. Ten per cent of the malignancies in our series biopsied were occult, and the breakdown of our statistics correlates fairly well with those of other authors although our series was not as large as some.

ACKNOWLEDGMENT

The authors wish to thank the Departments of Pathology of Baptist Medical Center and Deaconess Hospital for their splendid cooperation.

Special thanks also go to our tireless technicians and secretaries for help with the xeroradiographs and compilation of statistics as well as typing of the manuscript.

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Cancer Of The Pancreas Mortality In Oklahoma, (1950-1970)

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NABIH R. ASAL, PhD

A steady rise in cancer of pancreas mortality was found in Oklahoma. Mortality was also found to be higher in rural areas than metropolitan. This disease is the fourth leading cause of cancer death in the US with a five-year survival rate less than two percent.

There has been very little published in the area of the epidemiology of cancer of the pancreas. The available information indicates that cancer originating in the pancreas (International Statistical Classification of Disease [ISC] 157) is the fourth leading cause of cancer death in the United States. The incidence and mortality from the disease have been rising steadily over the last twenty years.² The survival rate for pancreatic cancer is very low, with the survival rate for five years being about two percent. This figure has not changed

greatly over the last twenty years. In the 1950's, mortality was 76% of reported incidence for whites and 50% for non-whites. Therefore it would appear that there was considerable under-reporting of mortality in the past, and part of the current rise in the mortality at this site is probably attributable to better mortality reporting. Cancer of the pancreas is uniformly higher in males than in females both in the white and non-white populations. This relationship has remained reasonably stable over the last twenty years. Male rates also are higher in international data for almost all countries reported by Segi.⁴

According to Segi,⁴ non-white rates in the United States are the highest in the twenty-four countries for which he reports mortality. The age-adjusted death rate in 1964 for non-white males was 9.8 per 100,000 and for non-white females was 5.9 per 100,000. Japan and Italy have the lowest rates for the twenty-four countries.

Men working in coke and gas plants, companies manufacturing β -naphthylamine and benzidine also have shown high death rates from pancreatic cancer. A study by Li¹ of members of the American Chemical Society showed an excess of deaths from pancreatic cancer. Alcoholics and heavy drinkers also have been suspected of having high death rates from the disease.³

Two reports published by Wynder *et al.*^{5,6}

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Table I
Annual Age-Adjusted Death Rates
per 100,000 Population, Cancer of the Pancreas,
Oklahoma, 1950-1970

Year	Rate	Year	Rate
1950	5.3	1961	7.8
1951	6.6	1962	8.7
1952	7.1	1963	7.5
1953	6.0	1964	6.9
1954	7.0	1965	7.7
1956	7.9	1966	8.8
1957	7.5	1967	8.7
1958	6.6	1968	8.6
1959	6.6	1969	9.4
1960	9.6	1970	9.0

METHODS

In the present study, the death certificate data from 1950-1970 except 1955 for all deaths in Oklahoma due to cancer of the pancreas was obtained from the State Department of Health. The year 1955 was missing due to the damage of a tape the data was stored on. Information for the general population was obtained from the United States Census reports. The usual epidemiologic and statistical analyses for mortality data were utilized. All adjusted rates were age-adjusted using the 1960 white male Oklahoma population as the standard.

RESULTS AND DISCUSSION

showed an association of pancreatic cancer with cigarette smoking in males and a significant relationship to early onset of diabetes and history of cholecystectomy in females. The authors suggested that bile containing carcinogens from tobacco or occupational environment, and possibly diet, might cause cancer on reflux into the pancreatic duct.

The purpose of this report is to analyze mortality from cancer of the pancreas in Oklahoma

The mortality rates obtained for the total population for each year in the study are shown in Table I. The age-adjusted death rates for Oklahoma reflect the general upward trend seen in national data, although the rise is not dramatic, and may be explainable for the most part by better diagnosis and improving certification and selection of underlying cause of death.

Table II presents the age-specific rates ob-

Table II
Age-Specific Death Rates per 100,000 Population, Cancer of the Pancreas,
Oklahoma, 1950-1970

Year	0-5	5-14	15-24	25-34	35-44	45-54	55-64	65-74	75+
1950	.00	.00	.00	.64	.67	5.19	12.38	22.24	55.69
1951	.42	.00	.00	.32	.33	6.39	17.76	37.07	48.55
1952	.00	.00	.00	.32	2.67	7.99	16.20	29.66	65.69
1953	.00	.00	.26	.31	1.00	5.59	16.20	25.21	57.12
1954	.42	.00	.00	.32	1.00	3.78	17.77	32.62	55.69
1955	—	—	—	—	—	—	—	—	—
1956	.00	.00	.30	.00	1.08	9.07	21.44	41.89	56.91
1957	.00	.00	.00	1.04	2.41	4.91	20.49	41.89	52.27
1958	.00	.00	.00	.70	2.06	4.91	16.20	35.35	53.43
1959	.00	.00	.00	.00	2.40	4.91	16.20	35.35	54.59
1960	.00	.00	.00	1.04	1.37	6.05	24.78	45.82	94.08
1961	.41	.21	.00	.38	1.05	3.98	15.09	45.83	74.38
1962	.00	.00	.00	.00	2.11	5.79	26.18	42.81	72.37
1963	.41	.00	.00	.00	.70	6.51	22.19	34.37	65.34
1964	.00	.00	.00	.38	1.41	6.87	21.71	26.18	60.31
1965	.00	.00	.00	.38	.70	6.51	21.30	39.20	64.33
1966	.00	.00	.00	.34	3.17	5.72	21.09	46.71	75.97
1967	.00	.00	.00	.33	.70	8.22	25.15	39.39	76.86
1968	.00	.00	.00	.00	2.46	7.51	20.28	42.21	77.56
1969	.00	.00	.00	.34	1.41	8.58	23.93	45.58	84.01
1970	.00	.00	.00	.00	2.11	7.51	27.18	38.83	80.44

Table III

Average Annual Sex-Specific Rates
per 100,000 and Sex Ratios,
Cancer of the Pancreas
Oklahoma, 1950-1970

Period	Male Rate	Female Rate	Sex Ratio
1950-1954	7.9	5.1	1.6
1956-1960	10.0	5.7	1.8
1961-1965	9.9	6.0	1.7
1966-1970	11.6	6.6	1.8

tained for each year. As may be seen, the disease is one primarily of the aged population. The average yearly and sex-specific rates and the sex ratio for the periods 1950-54, 1956-1960, 1961-1965, and 1966-1970 are shown in Table III. The male rates are uniformly higher than the female rates, with the sex ratio remaining fairly constant at about 1.65. This is again reflective of the national statistics for this site.

Figure 1 shows the age-specific sex ratio for the years 1965-1970. It appears that the sex ratio is highest in the middle years. This is again reflective of the national data, which also show the sex ratio to be highest in the middle years and declining in the very old.

A comparison of the white and non-white rates for the four periods is shown in Table IV. The non-white rates are not as high as those for the national population. However, the non-white population in Oklahoma includes a considerable Indian population, which would not be a factor in the United States data. Hence the non-white population in Oklahoma may not be strictly comparable to the non-white population of the United States. It would be worthy of note that the non-white rate has risen faster in the last twenty years than the

Table IV

Average Annual Race-Specific Rates per 100,000,
Cancer of the Pancreas,
Oklahoma, 1950-1970

Year	White Rates	Non-White Rates
1950-1954	6.6	4.9
1956-1960	7.8	6.5
1961-1965	7.6	8.6
1966-1970	8.9	8.1

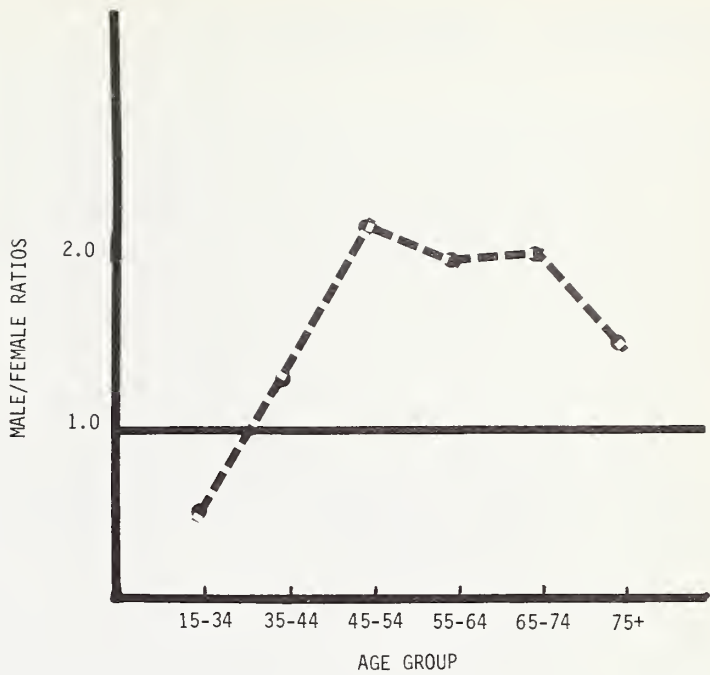


Figure 1. Age-Specific Sex-Ratios for Pancreatic Cancer Mortality, Oklahoma, 1966-1970.

white rate. It is possible that there may be considerable under-reporting of mortality in the non-white population in Oklahoma.

Lastly, it was desired to analyze the data by county to examine any possible urban-rural differences and to see if geographic trends exist. A mortality ratio for each of the seventy-seven counties in Oklahoma was calculated for 1965-1970, using the 1970 population as the denominator population. The expected number of deaths was calculated by taking the rate for the entire state and multiplying by the population of the county. The mortality ration was then calculated as observed/expected multiplied by 100. (Figure 2)

The two metropolitan counties both have mortality ratios considerably less than 100. In

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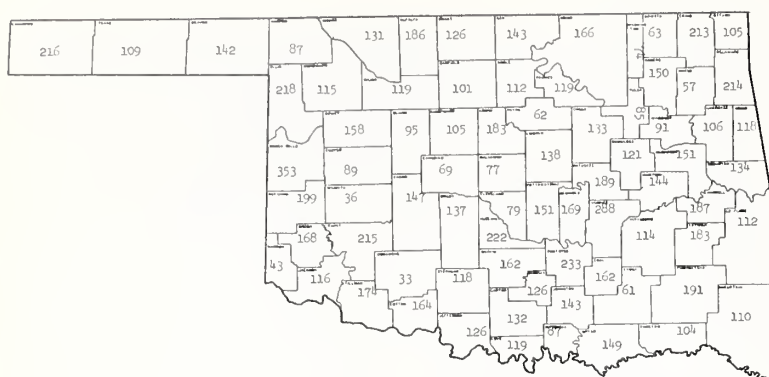


Figure 2. Pancreatic Cancer Standard Mortality Ratios By County, 1966-1970.

general, the trend is for the rural counties to have high mortality ratios and the urban counties to have low mortality ratios. However, the mortality ratio presented here is not adjusted for age, and since pancreatic cancer is more prevalent in the older age groups, this may account for most or all the observed differences.

SUMMARY

The mortality data for the state of Oklahoma was analyzed for the site cancer of the pancreas for the years 1950-1970, excluding 1955. It was found that the mortality rate has been rising slightly over the last twenty years. The rates for males are higher than those for females, with the sex ratio highest in the middle ages. The rates for non-whites were not observed to be higher than those for the white population, in contrast to national mortality data. It was thought that this may be due partly to the different nature of the non-white population in Oklahoma than the national population. The mortality ratios by county for the years 1966-1970 were calculated. The mortality ratios in general were higher in the rural areas than in the metropolitan areas.

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Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

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Early Onset of Seizure Disorders And Later Perceptual Problems: Case Reports

ELLIDEE D. THOMAS, MD

The sole finding of early onset of seizures may serve to alert the physician that perceptual problems could also be present. Appropriate testing should be done prior to school entrance.

Poor coordination, directionality-laterality difficulty, or choreoathetosis are commonly described in children with perceptual problems.^{1,2} Absence of these soft neurological findings does not rule out the possibility of a learning disorder, however, and physicians must be aware of other indicators. This paper reports six cases in which early onset of seizures was associated with later perceptual problems.

Four boys and two girls were classified as being at risk of having perceptual problems because of having had seizures during the first 18 months of life. The type of seizure as well as the electroencephalographic abnormality varied. (Table 1) The family was advised on the

initial visit to this examiner that the child should be tested for perceptual problems no later than during the kindergarten year. The test battery included the Wechsler Intelligence Scale for Children (WISC) or the Wechsler Preschool and Primary Scale of Intelligence (WPPSI), Bender-Gestalt, Frostig Developmental Test of Visual Perception (Frostig), Illinois Test of Psycholinguistic Ability (ITPA), and the Wide Range Achievement Test (WRAT). Table II summarizes the test results.

CASE REPORTS

Case I. A white female infant was the product of a third pregnancy. The mother had two febrile illnesses in the first and third trimesters with no specific diagnosis being made in either case. The baby was delivered with rotation from right occiput posterior position to occiput anterior after five hours of labor. Birth weight was 3.6 kg (8 lbs 1 oz); neonatal period was normal. She was seen initially by another pediatric neurologist at 10 weeks of age because of tremulousness, irritability, and stiffening. Examination showed only probably increased muscle tone in the upper extremities. Episodes of stiffening and jerking were seen and were thought to be myoclonic seizures. Mephobarbital and pyridoxine therapy was started.

When first seen by this examiner, the patient at 23 months of age was seizure-free, hav-

From the Department of Pediatrics and the Child Study Center, Children's Memorial Hospital, University of Oklahoma Health Sciences Center, and the Oklahoma Department of Institutions, Social and Rehabilitative Services, Oklahoma City, Oklahoma

ing become controlled soon after beginning medication. Growth and developmental milestones were normal, and no neurological deficit was found. EEGs continued to show seizure discharge until six years of age, and mephobarbital therapy was continued until then. She has remained symptom-free without medication, and continued follow-up showed no neurological problems.

The patient's overall intellectual ability was in the bright-normal to superior range when tested at five years, four months. Isolated deficits in visual association and visual-motor performance were found. The family chose to have the child tutored for a short time although they had been advised that she would probably do well at school in spite of these rather mild, well circumscribed difficulties. She has completed second grade with excellent performance and a happy school experience to date.

Case 2. A white male infant, the product of a second pregnancy, was born 2½ months prematurely weighing 1.4 kg (3 lb.). The mother had no specific problems during pregnancy except for mild spotting each month but she did not feel well the entire time. Labor and delivery were uncomplicated. The baby remained in the nursery until 10 weeks of age. Cyanotic spells appearing at two weeks of age were first

thought to be of cardiac origin, but were later identified as seizures. Phenobarbital therapy provided good control, and there were no further seizures.

The patient's developmental milestones were normal and he had no neurological deficit when he was seen at 14 months of age by this examiner.

The EEG was abnormal with both simple spike discharges and 14/sec and 6/sec positive spikes. Anticonvulsant therapy was continued until the EEG showed no seizure discharge at which time the patient was three years old. He has had no further seizures.

Testing done at five years, one month showed overall intellectual ability in the average range with indications of higher potential in verbal areas. Specific perceptual difficulties were found in eye-motor coordination, form constancy, and position-in-space perception.

Projective testing was also done with some indicators of mild difficulties in the child's emotional adjustment. Specific training for the perceptual problems was carried out. Re-evaluation prior to his entry into the first grade showed some perceptual problems persisting. He continued to receive specific tutoring and completed first grade with no academic, behavioral, or emotional problems apparent.

Case 3. A white female infant was the prod-

TABLE I
Summary of Type Seizure and EEG Abnormality

Case #	Onset	Description of Seizure	EEG
1	10 weeks	Myoclonic	Mixed: Atypical spike-wave complex, random simple spikes and 14/sec. and 6/sec. positive spikes mainly in right hemisphere.
2	2 weeks	Tonic	Non-focal simple spikes and 14/sec. and 6/sec. positive spikes in temporal and parietal regions bilaterally
3	18 months	Mixed: Possible grand mal. Petit mal, possibly some myoclonic components early	Initial paroxysmal slowing, sometimes bilaterally symmetrical and sometimes posterior right hemisphere. Later 3/sec. spike-wave complexes.
4	12 months	Focal: possible adverse eye movement, loss of muscle tone.	Non-focal simple spikes.
5	7 months	Hair pulling, irritability.	Non-focal slowing and spike discharges.
6	3-4 months, possibly 1 month.	Head tilting, screaming, vomiting, flushing.	Non-focal spikes.

TABLE II
Summary of Psychological Test Pattern
(WISC) and Perceptual Deficits

Case #	WISC Pattern	Perceptual Deficits (Frostig and ITPA)
1	Performance scores 9 points below Verbal score.	Visual-motor performance and Visual Association.
2	Performance score 30 points below Verbal score.	Eye-motor Coordination and Visual Association.
3	Verbal Score 5 points below Performance score.	Visual-motor and Auditory Association and borderline Auditory Memory.
4	Performance score 22 points below verbal score.	Block Design and Coding, Visual-motor Coordination, Position in Space, and Visual Memory.
5	Verbal score 13 points below Performance score.	Eye-motor Coordination and Figure Ground, Auditory Memory, Auditory Association and Auditory Reception.
6	Performance score 10 points below Verbal score.	Visual Memory. Indicators, but not specific deficit, in other visual tasks.

uct of a first pregnancy. Mild first trimester bleeding and edema, which was treated with diuretics, were the only complications experienced by the mother. Birth was possibly one month prior to expected date; a partial septum of the uterus was found. Presentation was double footling breech and the baby was delivered following 5½ hours of labor. The cervix clamped around the head and incision was made and the head delivered with forceps. Respiration was spontaneous and birth weight was 2.7 kg (6 lb 12 oz).

The neonatal period and early infancy were marked by the baby's crying all the time, but there were no other difficulties. Her first seizure occurred at 18 months and was associated with fever. No medication was given at that time. The first seizure without fever occurred when she was three years and three months old, and phenobarbital therapy was instituted. The patient was seizure-free for about 18 months when she began to have what were thought to be grand mal and petit mal attacks following an influenza-like illness.

This examiner first saw her when she was 57 months old. She was receiving mephobarbital and trimethadione, but petit mal seizures still occurred. Developmental milestones and results of neurological examination were normal except for the patient's frequent spells of staring. Various combinations of anti-convulsants

were tried, and good control was finally obtained with diphenylhydantoin, ethosuximide, and mephobarbital. However, because of slight, but persistent indicators of liver dysfunction, diphenylhydantoin and ethosuximide were reluctantly discontinued. Mephobarbital alone has continued to give good seizure control. EEG findings have varied from asymmetrical slowing only on the initial record, to spike wave on subsequent ones. EEG findings remain abnormal and medication has been continued.

Testing was done when the patient was six years, two months old and reportedly having difficulty in kindergarten. Overall intellectual ability was average with indicators of possible higher potential. Deficits in visual-motor areas and auditory association were found along with a borderline deficit in auditory memory.

Remedial educational tutoring was con-

A graduate of the University of Arkansas School of Medicine, Ellidee D. Thomas, MD, is presently Professor of Pediatrics at the University of Oklahoma Health Sciences Center and Director of the Child Study Center. Doctor Thomas is a member of the Child Neurology Society, the International Child Neurology Association and the Academy of Neurology.

tinued into the third grade. Testing done prior to fourth grade showed that the areas of previous deficits were all now within normal range, but the visual-motor functions remained relatively low compared to other visual skills. She did well in fourth grade work without specific help.

Case 4. A white male infant was the product of a normal second pregnancy. Labor lasted for 50 minutes, with the mother having received 75 mg meperidine prior to induction of general anesthesia. Respiration was spontaneous and the birth weight was 2.9 kg (7 lb 12 oz). Neonatal and early infancy periods were normal.

The father has a seizure disorder which probably started in adolescence but wasn't diagnosed until his late 20s. The child's first seizure occurred on his first birthday and was diagnosed as a minor convulsive disorder. EEG was interpreted as showing "evidence of seizure disorder." Phenobarbital therapy was started, and the patient was seizure-free for several months except for two hard seizures thought to be febrile convulsions.

This examiner first saw the child at four years, two months of age. Results of developmental and neurological examinations were normal, and no deficits were found on continued follow-up examinations. EEG findings have continued to show seizure discharge, and medication has been continued.

Psychological testing at five years, three months showed overall intellectual functioning within the superior range. Deficits were found in block design, coding, visual motor coordination, visual memory, and position in space perception. He was in kindergarten at the time of testing, but achievement tests indicated skills at first grade level in reading and arithmetic. The child was slow in pencil and paper tasks, however, and educational tutoring was done prior to first grade. He did well in first grade work without further help, but the family was advised to seek assistance if he began to have problems.

Case 5. A white female infant was the product of a second pregnancy. Edema was the only complication of pregnancy requiring medication. There was a short period of false labor two weeks prior to delivery. Labor lasted 3½ hours and respiration was spontaneous. Birth weight was 2.7 kg (7 lb 11 oz). The baby had club feet which were corrected with casts. Seizures were

thought to have begun at about seven months of age with irritability, hyperactivity, and later, pulling her own hair and head banging. Phenobarbital therapy produced a decrease in all symptoms except irritability.

She was seen by this examiner at two years, one month of age. Except for possible slight speech delay, results of developmental and neurological examinations were normal and have remained so with speech functions approaching normal. Irritability was marked.

EEG showed slowing and spike discharges. Because of irritability, mephobarbital was substituted for phenobarbital with fairly good seizure control, although occasional clinical indications of seizures have continued. Ethosuximide was then used, and seizures have been controlled with continued medication. Hyperactivity became a problem when the child entered school, and was ameliorated by administering amphetamine.

Psychological testing was done at five years, eight months of age. Overall intellectual functioning was in the low-end-of-average range, with some indications that potential was higher. Deficits were found in eye-motor skills, figure-ground perception, auditory memory, auditory association, and auditory reception. She was also noted to have a low frustration tolerance.

A self-contained learning disability class was recommended, but she was specially tutored since the class was not available.

She passed first and second grades with good school reports, but tested low on certain group achievement tests. Further testing showed drops in some specific areas, but these were thought to reflect an emotional rather than a perceptual status. She will continue to be followed.

Case 6. A white female infant was the product of a diabetic mother's first pregnancy. The mother experienced many episodes of hypoglycemia during pregnancy, three of which required intravenous glucose administration and two of these episodes probably resulted in shock prior to treatment.

Gestation was thought to be about 35 weeks. Labor lasted one and one-half days with the bag of waters rupturing two days before delivery. An intravenous pitocin drip did not precipitate birth, and delivery was by Cesarean section with the mother under spinal anesthesia. Respiration was spontaneous and birth weight was 3.5 kg (6 lb 4 oz).

The baby was in an incubator for four days

during which she was jaundiced but did not require specific treatment. Head tilting was noted at one month, and screaming and vomiting spells began two to three months later. An EEG at 10 months showed non-focal spikes. Diphenylhydantoin therapy was started and all symptoms lessened.

The patient was first seen by this examiner at 18 months of age. There were no clear developmental delays or specific neurological defects, and these indicators have remained normal. The EEG was equivocal with rare spike-like discharges in sleep only. Because of incomplete symptom control, however, phenobarbital was added to the regimen and symptoms cleared completely. EEG at age two years was normal, and medication was discontinued without the patient experiencing further difficulty.

Psychological testing at five years, ten months showed overall intellectual ability in the superior range. There were indicators of visual-memory difficulty and suggestive low areas in other visual tasks. Her achievement as measured by the Wide Range Achievement Test (WRAT) was above her kindergarten grade-placement but somewhat below expectations for her high overall intellectual ability. The family was advised that she would probably benefit from some specific training, although in our opinion she would continue to do well without specific help. They chose to have her tutored. She performed well in first grade with only minor problems in mathematics.

DISCUSSION

Within this small group, the type of maternal/infant difficulties encountered during pregnancy, labor, and delivery or in the neonatal period did not appear to correlate with the type of seizure or EEG abnormality and the perceptual problems found in the subjects. Until a larger group can be studied (study now in progress), it seems advisable to consider early onset of seizure disorder per se as a likely indicator of perceptual problems.

Although two of the children described here would probably have done well without specific educational therapy, each family chose tutoring as a preventive measure. Our experience shows that remedial care is easier and emotional problems are lessened by early identification of children with learning disabilities. Physicians must be alert to the possibility of perceptual problems in children with early onset of seizures and refer them for testing prior to their entry into school.

ACKNOWLEDGMENTS

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1:30 to 2:30 pm	Gastroenterology Conference	A001 Everett Hospital
2:45 to 3:45 pm	Pulmonary Problem Case Conference	C002 Everett Hospital
4:00 to 5:00 pm	Cardiology Conference	C007 Everett Hospital
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Oklahoma State Department Of Health The Goal — Clean Air

The health hazards of breathing polluted air are quite well documented. Prolonged exposure to air pollution increases the morbidity and mortality rate of respiratory diseases. The Air Quality Service of the Oklahoma State Department of Health is charged with the responsibility of monitoring pollutant levels in the ambient air, keeping emission inventories from all major sources, reviewing performance standards of controls, investigating complaints and achieving overall compliance with required standards.

The Air Quality Service maintains a statewide air surveillance network that monitors the concentrations of particulate matter, sulphur dioxide, nitrogen oxides, photo-chemical oxidants and carbon monoxide. The primary standards for these pollutants allow an adequate margin of safety to protect the health of the public, while the secondary standards aim to protect the public welfare from any known or anticipated adverse effects associated with the presence of air pollutants.

Annually the Air Quality Service prepares



News From The Oklahoma State Department of Health

an *Oklahoma Air Quality Report*, available for free distribution in limited quantities, which presents a statistical analysis of pollutant data and provides information for trend analysis and formulation of control strategy. Generally the conditions of Oklahoma air are steadily improving as manifested in the reports. In 1974 the particulate concentrations met the primary annual standard at 79 monitoring sites compared to 73 in 1973. Reductions were also noted in other categories.

The designation of Oklahoma City and Tulsa and their vicinities as Air Quality Maintenance Areas marks one step in long-range planning undertaken by the Service to facilitate the attainment and maintenance of clean air standards to the year 1985. The service is continuing in these and other areas to ensure that the Oklahoma air is clean. □

COMMUNICABLE DISEASES IN OKLAHOMA FOR AUGUST, 1975

DISEASE	August 1975	August 1974	July 1975	TOTAL TO DATE	
				1975	1974
Amebiasis	6	6	7	22	20
Brucellosis	—	1	—	3	5
Chickenpox	6	6	20	950	806
Encephalitis, Infectious	7	2	10	38	39
Gonorrhea (Use Form ODH-228)	1324	1107	1133	8578	7391
Hepatitis, A, B, Unspecified	40	60	54	540	703
Leptospirosis	—	—	—	—	1
Malaria	—	—	—	1	3
Meningococcal Infections	—	1	—	9	15
Meningitis, Aseptic	12	8	18	48	45
Mumps	10	11	24	183	369
Rabies in Animals	5	15	7	77	112
Rheumatic Fever	—	2	1	7	9
Rocky Mountain Spotted Fever	5	7	20	72	53
Rubella	3	8	—	85	44
Rubella, Congenital Syndrome	—	—	1	1	1
Rubeola	—	1	9	126	25
Salmonellosis	41	31	16	143	172
Shigellosis	42	20	29	238	108
Syphilis, Infectious (Use Form ODH-228)	12	6	6	60	93
Tetanus	7	1	—	—	1
Tuberculosis, New Active	29	25	19	221	194
Tularemia	3	3	1	9	13
Typhoid Fever	—	1	—	—	2
Whooping Cough	3	2	4	22	14

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Governor's Workmen's Compensation Commission Begins Study

Governor David Boren has charged his Special Advisory Committee on Workmen's Compensation with the responsibility of studying every aspect of Oklahoma's Workmen's Compensation Laws. In a letter to Senator Ed Berrong, Chairman of the panel, Governor Boren said ". . . Oklahoma benefits are among the very lowest in the entire nation; while, at the same time, the rates for insurance premiums being paid by our employers remain among the highest of all surrounding states. Something must be radically wrong with our present system which has allowed this imbalance to continue for so many years."

The Governor's letter, read and distributed to each member of the Commission, outlined areas for study and correction. While expressing concern over low benefits and high premiums, the Governor also challenged the efficiency of the present system. "No system of . . . Workmen's Compensation is free," said the Governor. "It already costs a great deal of money just to provide the present system together with its low level of benefits. This should not deter us in our efforts to make our Workmen's Compensation system a model for the nation in providing prompt and realistic help to those who suffer loss due to job related injuries . . . but any such increases must be made in a responsible manner which will insure that these higher benefits go only to those workers who are genuinely injured."

The Governor assured the Commission that one of his top legislative priorities will be the reform of the Compensation Act, and asked that the following points be considered:

- (1) Extension of benefits to the thousands of employees who are not presently covered;
- (2) An increase in benefits for the injured worker (now limited to \$50.00 per week);
- (3) A rehabilitation program for the injured;
- (4) An administrative section to assist the Industrial Court in expediting cases.
- (5) The creation of an impartial medical pan-

el to review cases when a significant variance in medical opinion exists.

The association is represented on the Commission by David Bickham, Associate Executive Director, who participated in a similar study several years ago. "The system has changed little, if any, since the 1968 study," said Bickham. "The testimony presented then is just as appropriate today. Our Occupational Medicine Committee and Legislative Committee are reviewing previous studies and preparing comments for the Commission. Most of the things suggested by the Governor have been recommended before. We hope the Governor and legislative leaders will exert the necessary political pressure to accomplish reform, but we know it's an uphill battle." □

GAO Says SRS Funds "Face Exhaustion"

Watchdog of federal spending, The General Accounting Office, reports that Social Security's trust funds "face exhaustion in the near future because of increased benefit levels due to inflation, and high unemployment causing reduced contributions . . ."

The GAO announcement may have delivered a death blow to the possibility of National Health Insurance plans relying on Social Security financing. According to GAO, projections covering the next 75 years show that the Social Security system will also incur a large, long-range deficit because of the decreasing birth-rate and the rising cost of living.

In order to alleviate the situation, GAO pointed out, Congress will have to approve some of the remedies already suggested by various advisory bodies, including financing of Medicare Part A out of general revenues, the equivalent of adding a new \$9 billion annual spending program.

The money saved for Social Security, \$9 billion, would be used to support other Social Security programs, primarily the main retirement disability program. Social Security taxes would not be changed, but federal corporate and income levies presumably would have to furnish an extra \$9 billion.

Unless such steps are taken, GAO warned, "there may be no alternative to increasing (Social Security) taxes" or the wage base or both. □

Oklahoma Supreme Court Decides Optician Case

An optician may use a keratometer or ophthalmometer to aid in the fitting of contact lenses according to the Supreme Court Decision in the case of State of Oklahoma versus Leonard Reeser.

The decision, in which all Justices concurred, also ruled that an optician may not duplicate lenses of any type without a written prescription. In reaching this latter decision, the court relied on a 1955 Oklahoma case Williamson versus Lee Optical of Oklahoma. In that case the court construed a state statute to say that no optician could supply a lens, whether it was a new lens or a duplicate of a lost or broken lens, without a written prescription.

Because of this Lee Optical decision, the Supreme Court reiterated the necessity for a "written" prescription from an ophthalmologist, oculist, or optometrist before an op-

tician could duplicate a regular or contact lens.

In regard to opticians fitting contact lenses, the Supreme Court said, "the optician does not decide whether or not a patient may wear contact lenses. This is indicated on the prescription. The optician does not use the keratometer to measure refraction or astigmatism. The patient is advised to return to the examiner for assurance as to proper fit. If all ophthalmologists would be required to purchase a keratometer and take the extra time to use it in making measurements for the fitting of contacts, this might result in a disservice to the patient in added expense."

The Oklahoma State Medical Association filed a brief in the case while it was pending before the Supreme Court. Ophthalmologists in the state of Oklahoma were concerned because no ophthalmologist had testified at the original trial and subsequently the trial court did not have expert testimony on the views of ophthalmologists toward opticians and the use of the keratometer. □

(Continued from Page 374)

In setting up this Professional Liability Study Commission, we must constantly keep in mind that their group is a part of the Oklahoma State Medical Association organizational structure, and in doing so the Commission will work with the related committees and councils of the Association. Any final plans reached by this Commission will be presented to the Board of Trustees or to the House of Delegates for final approval.

The work of the Study Commission will be of a priority nature. They will receive my personal support so long as they keep in mind that their duty is for the good of all of the membership of the Oklahoma State Medical Association. I know they will work hard on this important project and I also know they will make progress. I know too, that this Study Commission at times will be disappointed and frustrated and that the goals of their game plan cannot be accomplished in one year. As in the past, a healthy legal atmosphere will require continuing vigilance and day to day management decisions.

The Study Commission has already had its first meeting, and I personally was very enthused with the many and varied activities that were discussed. I have been directed, as

President of your Association, to discuss with the authorities of the University of Oklahoma Health Sciences Center the possibility of teaching more about malpractice to Junior and Senior Medical Students. It is our understanding that a professional liability course is being taught only to the freshman class in the College of Medicine. The Commission feels that more could be gained by offering the course to students who are nearer to graduation. The Study Commission is probing the idea of offering more professional liability study courses, with a possibility of decreasing one's insurance rate when satisfactorily completing one of the prescribed seminars. I would expect that such a course would need to be repeated approximately every three years in order to remain on the reduced rating list.

It is my personal opinion that this professional liability study program will be a great asset to our association in the years ahead in maintaining the number one position in our statewide insurance program. I can't help but be very enthusiastic about this important subject area.

I request, once again, that every member of our association unite to keep our insurance program stable.

Arnald G. Nelson, M.D.



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Internal Medicine Course Available Via Television

Physicians wishing to brush up on their internal medicine skills will be able to do so this fall for the first time without having to travel to distant college or university facilities.

By use of the televised instruction system sponsored by the Oklahoma State Regents for Higher Education, state physicians may enroll, via talk-back television, in the internal medicine review course being offered September 18th-December 18th by the University of Oklahoma Health Sciences Center.

Dale Groom, MD, Review Course Coordinator, said the course is being scheduled on talk-back television to eight physicians living outside the Oklahoma City area in updating their medical skills.

The internal medicine review course is offered annually by the Health Sciences Center Office of Continuing Medical Education for physicians and the Department of Medicine. It covers such topics as clinical pharmacology, solid tumors, hemotologic oncology, immunology, neurology, hyperlipoproteinemia, genetics, bleeding disorders, rheumatology, and allergy-immunology.

Physicians interested in taking the course should contact the local facility housing the closed circuit television equipment and classroom space. The course operates each Thursday night from 5:00 until 6:30 pm and will be charged the course fee of \$35 and an additional \$15 transmission fee.

Cities able to receive the talk-back television class and locations of the facilities are: Oklahoma State University, Stillwater; University of Tulsa; Oral Roberts University, Tulsa; Tulsa Junior College; Tulsa Vo-Tech; Phillips University, Enid; Northeastern Oklahoma State University, Tahelquah; Bartlesville Wesleyan College; Phillips Petroleum Company, Bartlesville; Bureau of Mines, Bartlesville; Continental Oil and Ponca City Hospital, Ponca City; Muskogee Veterans Administration Hospital; Muskogee High School; and Northern Oklahoma College, Tonkawa.

Doctor Groom said the internal medicine review course, whether taken at the Health Sciences Center or via talk-back television is acceptable for one and one-half hours per session in Category I for the Physicians's Recognition Award of the AMA and the American Academy of Family Physicians. □

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HSA Task Force Recommendations Nearing Completion

The state's Health System Agency may soon be officially organized. A Governor's Task Force will soon complete its function of preparing suggestions on the corporate structure and composition of the first HSA Board of Directors for David Boren. Apparently, the study group has decided that a private "not-for-profit" corporation should be organized to implement requirements of Public Law 93-641—The National Health Planning and Resources Development Act of 1974. The non-profit corporation is one of the three options available to the Governor under the law. The others were "units of government" or a "regional planning body." Most observers expected the new corporation approach which obviates the certain political competition and inter-agency fighting if either of the other methods were selected.

Of less certainty is the manner in which the original board will be selected. Boren's decision to elect the single HSA option has created

substantial problems in selecting the first-governing body. Under the law (Oklahoma and Federal) it appears that the board will have thirty members. Sixteen, according to the Federal Act must represent consumers. The other 14 are to be selected from the ranks of direct and indirect providers — the definition of which includes everyone from physicians to health insurance salesmen. The major provider organizations are vying for specific representation on the board, and rural representatives want to be assured of an adequate voice. Others feel the sub-area councils (six) should be organized and submit nominees for representation on the original board.

Members of the Task Force are working with various options for the Governor's consideration. Each of the proposals will attempt to provide for nominees from sub-area councils and government; and consideration of representation by sub-area population.

Regardless of their suggestions on formations, Governor Boren will choose the first board and sub-area councils, his appointees may well determine the future course of health planning in Oklahoma. □

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Generic Drug Marketing Stymied by Federal Court

A Federal court ruling threatens to cramp the Food and Drug Administration's plans to make it easier for "generic drug" makers to market their products quickly after patent protection runs out on brand-names.

An order by US District Judge, June Green in Washington, DC, blocked FDA from allowing Zenith Laboratories of North Vale, New Jersey, to market a generic version of chlor-diazepoxide without first obtaining a new drug application. The ruling was sought by Hoffman-LaRoche, Inc., which markets the product as Librium.

Judge Green said the NDA requirement for generic drugs has an anticompetitive affect. But "the overriding interest in insuring the health and safety of the public through compliance . . . requires the result reached here."

Securing a new drug application for a product is a lengthy and extensive procedure, requiring test data, etc., and would delay for a long period introduction of competitive "generic" drugs in cases where patents have lapsed.

If upheld by higher courts, the ruling could hurt the HEW Department's controversial maximum allowable cost . . . known as MAC . . . program intended to foster purchase of generic drugs by Medicaid patients. MAC has been challenged in federal court by the American Medical Association. □

Oral Diabetic Drug Warning Debated

Strong arguments for and against warning labels for oral diabetic drugs were heard at an unusual one-day hearing conducted by the Food and Drug Administration. The argument has become one of the agencies keenest medical-scientific controversies in the past five years.

A new British study and a testimony of one of the original American investigators casts some doubt on the validity of the scientific data FDA had been relying upon in its efforts to crack down on oral hypoglycemics. On the other hand, one of Ralph Nader's health teams contended the warning label was insufficient and called for written consent by patients before taking the oral products.

The hearing was called to further air the differences of opinion on the FDA's proposed warning that there may be increased risk of cardiovascular death in diabetic patients

treated with the oral drug. The proposal is based on a 1961-1970 clinical study by the university group diabetes program which claimed the heart disease death rate was twice as high among patients treated with the oral drugs compared with those on insulin or special diets.

A double blind study by University of London professor Harry Keen suggested evidence of long-term benefits from Tolbutamide and Phenformin and no long-term cardiovascular toxicity. An FDA official said this latest study, carried out over an eight-year period, will require close consideration.

The FDA received information that the UGDP study may have been prejudiced by a conflict of interest on the part of one of the investigators. It was told that it "might be on mighty thin ice" if it goes forward with its plans to require warning labels without first investigating whether the study was actually valid. □

Editorial

(Continued from Page 373)

consistent with the findings reported elsewhere in that dramatic elevations of cholesterol (up to 500 mg/dl.) and CPK (up to 1435 units) are virtually always seen in profound hypothyroidism, yet all return to normal as euthyroidism is approached.

Hypothyroidism need no longer be a guessing exercise in medicine. The tools to recognize it are available and should be used. *James L. Males, MD, Department of Medicine, Oklahoma City Clinic and Section of Endocrinology, Department of Medicine, University of Oklahoma Health Sciences Center.* □

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DEATHS

EARL D. McBRIDE, MD
1892-1975

Earl D. McBride, MD, 84-year-old, retired founder of the Bone and Joint Hospital and McBride Clinic in Oklahoma City, died September 20th, 1975. As an orthopedic surgeon, Doctor McBride pioneered work for crippled children in Oklahoma. A 1914 graduate of Columbia University College of Physicians and Surgeons, New York, Doctor McBride served with the Medical Corps in World War I and as a consultant to the Surgeon General of the US War Department after World War II. In addition to his private practice, he was a Clinical Professor of Orthopedic Surgery at the University of Oklahoma Health Sciences Center.

Doctor McBride was active in many medical organizations having served as the first President of the Oklahoma City Clinical Society; was a charter member of the Association of Bone and Joint Surgeons; and a member of the American Orthopaedic Association, the Clinical Orthopaedic Society, the Southern Medical Association, the Industrial Medical Association and the American Fracture Association. He was a Life Member of the Oklahoma State Medical Association.

CHARLES W. JOYCE, MD
1881-1975

Charles W. Joyce, MD, a Fletcher physician for 70 years, died in Lawton, August 31st, 1975. Born in Westfield, North Carolina, September 22nd, 1881, Doctor Joyce was graduated from the University of Tennessee College of Medicine in 1903. He practiced in Elgin and Wheatland before moving to Fletcher in 1912.

Doctor Joyce was honored in 1954 when the OSMA made him a member of the Fifty-Year Club and again in 1957 when he received an OSMA Life Membership.

ROBERT H. AKIN, MD
1904-1975

Robert H. Akin, MD, an Oklahoma City urologist, died September 16th, 1975. A native of Watonga, Oklahoma, Doctor Akin was graduated from the University of Oklahoma College of Medicine in 1928. Doctor Akin was active in urological circles and held memberships in the South Central Section of the American Urological Association, the Sociedad Mexicana de Urologia, the American Urological Association, the American College of Surgeons and was a Diplomat of the American Board of Urology. In 1971, the Oklahoma State Medical Association presented Doctor Akin with a Life Membership.

RAYMOND E. SELDERS, MD
1892-1975

Word was received by the Oklahoma State Medical Association, that a 1927 University of Oklahoma College of Medicine graduate, Raymond E. Selders, MD, had died August 31st, 1975, in Houston. Doctor Selders was a retired general surgeon and will be remembered by many Oklahoma physicians.

GLENN H. YEARY, MD
1905-1975

Newkirk physician, Glenn H. Yeary, MD, 70, died September 12th, 1975. A native of Elmore City, Oklahoma, Doctor Yeary was the brother of E. Curtis Yeary, MD, a Ponca City physician. He graduated from the University of Oklahoma School of Medicine and took his internship at Kansas City General Hospital before establishing his practice in Newkirk in 1933.

Doctor Yeary had earned the admiration and love of the small community for his long years of devoted service to its citizens. He was also recognized as one of the most astute medical diagnosticians in Kay County. □



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INTERNIST: Immediate opening for chief medical service of 408-bed Veterans Administration Center located in warm climate of Texas. Sixty-five miles from downtown Dallas. Salaries based on education, experience and background. Paid vacation, sick leave, malpractice and life insurance, and other fringe benefits. Interested physicians please write or call George H. Hassard, MD, Chief of Staff, Sam Rayburn Memorial Veterans Center, Bonham, Texas 75418. Telephone 214 583-2111, ext. 212. Inquiries confidential. An equal opportunity employer.

FAMILY PRACTICE: Attractive salary with small group serving outpatient department in Texas city of 156,000. 35,000 - 50,000 patients per year. All fees paid by hospital. Send C.V. Call collect and in confidence to Toni Clark 512 349-2651. Daniel Stern and Association, Health Placement Services, Suite 510 GPM South Tower, San Antonio, Texas 78216.

PRIMARY CARE PHYSICIAN. Kansas State University Student Health Center and University Hospital anticipates an opening in its professional medical staff beginning October 1st, 1975. The Center and Hospital is accredited by the Joint Commission on Accreditation of Hospitals and includes a busy outpatient clinic, laboratory, diagnostic X-ray, mental health, pharmacy, physical medicine and 26-bed hospital. We are looking for an energetic primary care physician to join our medical staff of eight, with a supporting professional staff of seventy. Activity involves general practice with some office orthopedics, office gynecology, and office ophthalmology. Office hours are 8-5 with on call schedule averaging four to five days per month. Salary range: \$25,500-\$30,000 depending on experience and qualification. Fringe benefits include one month vacation plus paid postgraduate education meetings. Experience in private medical practice is desired. Kansas State University is an equal opportunity employer. For further information please write Director, Lafene Student Health Center and University Hospital, Kansas State University, Manhattan, Kansas 66506.

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WELL-TRAINED INTERNAL MEDICINE specialist needed immediately for medium-sized Oklahoma city with outstanding hospital facilities and full range of specialty care. Existing practice nets \$60,000 a year. Contact Key W, *The Journal*, Oklahoma State Medical Association, 601 NW Expressway, Oklahoma City, Oklahoma 73118.

CLAREMORE, 20 MILES NORTHEAST OF TULSA in the heart of Green Country, is in need of family physicians and internists. Office space is available within one block of a newly expanded 105-bed, fully accredited hospital. This progressive medical community is highly desirous of attracting new physicians as soon as possible. Interested parties should contact Larry I. Young, MD, Drawer B, Claremore, Oklahoma 74017, 918 341-5311. □

Immunization Action Month

The month of October has again been designated as Immunization Action Month and auxiliary members are urged to join in the cooperative effort to reach and motivate parents of pre-school children to immunize against polio, measles, rubella, mumps, diphtheria, pertussis and tetanus. Surely we will do everything we can, either individually or as an auxiliary, to reach the unprotected children in our communities. One of the objectives of the auxiliary is to assist the medical association in its program to improve the quality of life through health education and service. We can play a vital role in our own community by telling the public preventive medicine does work.

Immunization Action Month was initiated in 1973. It was designed to break the apathy toward vaccine preventable disease throughout the United States. According to information from the Immunization Division of the Center for Disease Control in Atlanta, Georgia, the efforts have been successful. The 1974 US Immunization Survey shows that an increase has occurred for all vaccines in the one to four year age group. The extra effort put forth by participating organizations during Immunization Action Month in 1973 and 1974 have reversed the declining trend. This year, however, we must not grow complacent but increase our efforts, keeping in mind the immunity levels among one to four-year-old children are still low enough to sustain substantial spread of disease, including outbreaks.

David E. Adcock, administrator of the Immunization Program in Oklahoma, has expressed appreciation for our help and support and has asked that we continue to provide Oklahoma parents with information explaining the need for adequate and complete immunization early in life. We must continue to provide information not only on a one-month basis as we do in Immunization Action Month

but on a 12-month basis. Your county auxiliary can help by:

1. Checking your own family immunization record now.
2. Be informed and inform others. Know the threat of childhood diseases and be informed about the means and methods of combating them.
3. Work with other participating organizations. Ask your medical association and your health department how you can work with them.
4. Reach parents through clubs, church groups, county fairs, PTA, etc.
5. Sponsor spot announcements on radio and TV.
6. Ask the mayors of the towns and cities in your county to join Governor Boren in issuing an IAM Proclamation calling on all our citizens to join in a crusade to assure complete immunization for all our children.

An interesting Immunization Project came to us from our "Idea Exchange" with other states. One state auxiliary launched its immunization action at the request of and in cooperation with their state medical association. Everything from flyers in grocery shopping bags to messages on milk cartons characterized the all-out effort in delivering the message, "You Can Prevent It." In order to reach the parents of new-born infants the auxiliary printed a brochure to be taken home from the hospital. It not only contained helpful information but a handy record card for immunization records.

Since each county is different and so are the talents and personalities of its county auxiliary members, only you can decide how you can work best with the other participating organizations in the Immunization Program. *Jewell Coates - Community Health Chairman - Auxiliary to the Oklahoma State Medical Association.* □

Professional Liability Commission Holds First Meeting. A blue ribbon commission authorized by the Board of Trustees and appointed by Arnold G. Nelson, MD, President, has held its first meeting to discuss the malpractice insurance crisis. The panel, composed of medical specialty representatives, OSMA officers, insurance representatives, defense attorneys and the general council spent Sunday afternoon in a lengthy meeting discussing the problems of availability and cost of liability insurance. C. Alton Brown, MD, head of OSMA's Council on Insurance, chairs the Commission who will make recommendations to OSMA's Board of Trustees for corrective action. It is anticipated that a number of legislative recommendations will result from the Commission hearing.

Other areas of concern include legal education for physicians — how to avoid being sued and continuing medical education to insure up-to-date information on the latest medical techniques and knowledge.

While Oklahoma enjoys a favored status among all states nationwide as far as insurance rates are concerned, the commission fears that it is simply a matter of time before the "crisis" reaches the state.

Preventative measures of a relatively minor nature could avert the East and West coast disasters that drew national attention to the problem, said C. Alton Brown, MD, Chairman of the Commission.

HEW Team To Visit Oklahoma. A team of health officials representing Theodore Cooper, MD, Secretary of Health, Department of Health, Education and Welfare, will visit Oklahoma to finalize the Hospital Cost Effectiveness Plan (utilization review). "Because the plan is now being considered as a national prototype, its evaluation has become extremely significant," said Don Blair, Executive Director of OSMA. "In fact, if the plan is successful it could substantially alter the implementation

of PSRO." Labeled "Focused Review" by federal officials, the plan waives most review requirements for institutions that deliver care within acceptable norms. "Our idea" explained Blair, "was to design a system that was least disruptive to physicians and hospital routine. CEP is a retrospective analysis of hospital data that identifies problems. We assume that physicians and institutions will want to correct deficiencies when they have been isolated.

The Oklahoma Foundation for Peer Review will monitor the program when it has received formal approval. David Matthews, Secretary, Department Health, Education and Welfare in a meeting with Senator Bellmon and OSMA officials, indicated he would approve the plan if recommended by Doctor Cooper. Cooper, one of the earliest supporters of the alternative approach, has approved the plan subject to successful resolution of minor legal problems.

Medicare Leaflet Spreads to Other States. Louisiana and Arkansas followed Oklahoma's lead in giving widespread distribution to the "Your Medicare Benefits are Being Cut" leaflet. Oklahoma physicians have already used 250,000 of the leaflets and reports from the other states indicate that their initial supplies were quickly depleted.

OSMA Annual Business Meeting to be Separated from Summit. The Board of Trustees has approved recommendations by Arnold G. Nelson, MD, that the annual House of Delegates meeting be held at a time different than that of Summit '76. "Annually we receive a considerable number of complaints from physicians who cannot attend the Summit Scientific Sessions because they are involved in the business aspects of association affairs," said Nelson. "By moving the meeting to another time we eliminate conflicts and can reduce business sessions to the minimum time." Tentative plans call for the House of Delegates meeting to be held at the Skirvin Hotel, April 10th and 11th, 1976. □

The

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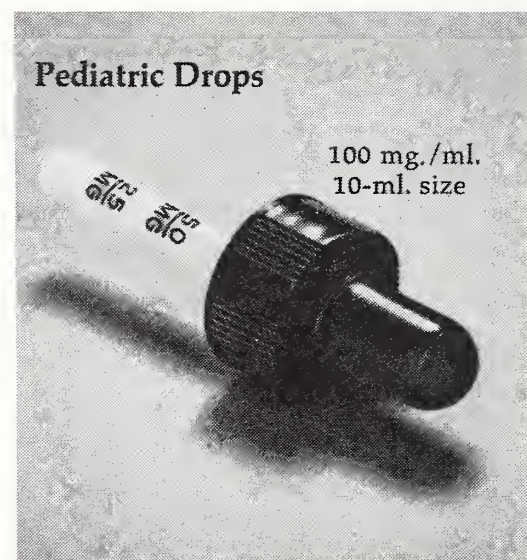
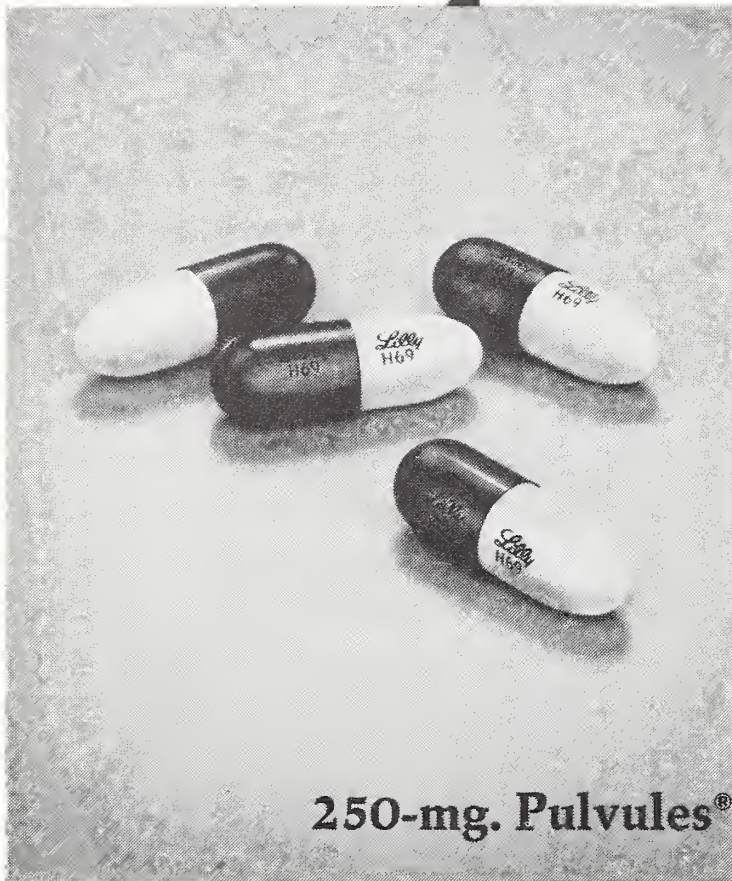
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Drug Substitution: Many Promises—Few Results

Not long ago, a physician in Eau Claire, Wisconsin, closed his practice and moved to another state. His reason “. . . self-seeking political interferences have become so intolerable that I can make no other possible decision.”

One of the interferences is proposed legislation that would allow drug substitution without the knowledge or approval of the physician. The same legislation that helped force the Wisconsin physician to close his practice and leave the state is now an issue in Oklahoma, and its chief backer, Representative Mark Hammons, plans to once again push for its passage. The Hammons bill, H.B. 1160, is with the Senate Committee on Public and Mental Health and will be considered next year.

Substitution is superficially enticing because it allows the patient to request the pharmacist to replace the prescribed drug with a lower priced, generic equivalent. In fact, the patient would be *encouraged* to do so because pharmacies would be allowed to advertise a “cost counseling” service. Drug selection, then, would be based entirely on price. Even when cautioned by the pharmacist, the patient would be in total charge of drug selection. The net effect would be to lower health care standards in the name of non-existent savings to the patient.

The only reason for H.B. 1160 is to save money, but based on a 1973 study, the average consumer would have only saved 43 cents on all of his drug purchases that year if generics were used whenever possible. In Canada, where substitution has been allowed for ten years, there have been no demonstrable savings to the patient.

And what price would the patient pay for these negligible savings? Perhaps a high one! Not only could poorly made drugs create health hazards, but they also could cause illnesses to linger. If the Food and Drug Administration could guarantee the quality of the billions of doses of prescription drugs, there would be no problem with choosing drugs generically. However, the FDA cannot make such a guarantee, and so the risks of generic substitution are high.

For example, in 1972, the US Air Force purchased a foreign-made tetracycline antibiotic, assuming that it met published standards and was equivalent to the major brand name pro-

duct. The drug did not dissolve properly in servicemen being treated for penicillin-resistant gonorrhea, and infections of the urinary tract resulted. Proponents of H.B. 1160 believe that all generic equivalents are made with the same care, but, in this case, and in many others, physicians have found just the opposite to be true.

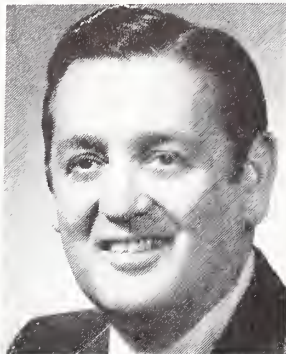
While substitution is mainly a health question for patients, it also raises serious liability questions for physicians who need no added surprises. The transfer of drug selection responsibilities from the physician to the pharmacist could involve doctors in an increased number of malpractice claims, because the doctor is almost sure to be named in any lawsuit involving a drug-related injury or an unnecessarily prolonged illness. Even if the doctor is always found *not liable*, the cost of defense will force insurance rates higher and add problems to an already crisis situation.

On the other hand, since an overwhelming number of American citizens want drug substitution, it is an issue that must be carefully considered, right? Wrong! According to a national survey, less than 30 per cent of the persons surveyed favor the substitution of chemically-similar drugs. In a California survey of persons aged 55 and over, 83 per cent were opposed to delegating drug product selection to the pharmacist, and this is the very age group drug substitution is supposedly designed to help.

So, substitution comes down to an issue that potentially threatens the patient's welfare, offers no substantial savings, threatens to heighten the malpractice insurance crisis, and is opposed by a broad cross-section of the public. And, yet, the Oklahoma Legislature will probably reconsider the bill during its next session.

There is no reason for Oklahoma to experiment with a law which has already failed in several other states and in Canada. Every physician, pharmacist, and patient should be familiar with H.B. 1160 and its possible serious effect on health care in this state. *Richard Hess, Director of Communications, Oklahoma State Medical Association.* □

For several years, the Oklahoma State Medical Association has been concerned about Oklahoma's system of workmen's compensation. On October 14th, David Bickham, OSMA Associate Executive Director, R. Barton Carl, MD, John Blaschke, MD, and I were asked to testify before the Governor's Commission on Workmen's Compensation. We made it quite clear that we were very concerned about the Commission's activities.



We in Oklahoma realize the importance of a workmen's compensation program that is equitable to the injured worker, the employer and the insurance carrier. We stand behind the principle and philosophy that the injured working man should have the very best medical care, adequate benefits while unable to work, unending efforts from all parties to speed his return to the job, rehabilitation if necessary, and adequate compensation for permanent effects resulting from the disease or injury. While we are concerned about costs, we believe costs should be secondary to the patient's welfare.

It has been shown that workmen's compensation costs in this state exceed the costs in surrounding states. It has also been stated that the benefits here are not in line with the cost of the program.

While we believe in quick, adequate benefits for the injured, there is no question that a return to employment is more desirable to the injured employee. The opportunity to earn a living while being treated for an injury would reduce the economic disaster experienced by many of our injured workers. At the same time, it might also reduce the amount of disability payments by allowing the worker to earn income while receiving treatment. Under our present system, however, it is difficult, if not impossible, for the injured man to return to work until he has been completely released by his attending physician.

I feel a study should be made of this aspect of workmen's compensation. Through education, statute, or otherwise, an environment should be created where an injured worker can be accepted on

the job prior to final release by his attending physician. At the same time, the physician should be relieved of his present responsibility for evaluating permanent disability. Doctors are students of science, skilled in making scientific judgments. We should be allowed and asked to give opinions only on impairment of functions, not on permanent disability.

I urge consideration be given to utilizing the work and studies of national committees on disability evaluation, particularly guides which are available through the American Medical Association. These guidebooks could aid the physician in determining physical impairments. I would also support the creation of a panel of physicians to review medical questions which seem to have a significant divergence of medical opinion. This panel should be composed of physicians from all types of practice, and participating physicians should be able to obtain x-rays and other laboratory studies previously performed by other physicians. He should also be allowed to make any additional tests necessary to make a proper evaluation of the injury. The panelist-physician should, of course, be paid for his services by the Oklahoma Industrial Commission. Although a great deal of study would have to be given to the medical panel system, once operational, it would probably save a large sum of money.

Your representatives who appeared before the Commission looked closely at workmen's compensation and made these specific recommendations:

1. Physicians should only determine physical impairment. The question of permanent disability should be determined by the court.

2. A medical panel should be created to resolve medical disputes before the court.

3. A study should be made of the feasibility of a permanent medical director for the Oklahoma Industrial Court.

4. Additional safety programs should be instituted.

Those of us who testified before the Governor's Commission on Workmen's Compensation felt good progress was made. It will, of course, be necessary to pursue our recommendations and consider others.

Once again, I ask for unity among all physicians in this state in solving this very difficult problem.

Arnold G. Nelson, M.D.

The Electric Tic Procedure: A Safe Percutaneous Method for Relief of Trigeminal Neuralgia

RICHARD V. SMITH, MD

Utilizing a 1914 approach developed in Europe with subsequent modern day refinements, a low morbidity, highly successful technique has been developed to treat trigeminal neuralgia.

Trigeminal neuralgia is for the most part a disease process affecting the elderly patient who often harbors a brittle cardiovascular or pulmonary status making the risks of general anesthesia and major intracranial surgical procedures excessively high. However, regardless of risk, the result of tic pain is very often so incapacitating and refractory to medical management that surgery becomes the only acceptable form of treatment.

Utilizing a percutaneous technique described by Hartel² in 1914 to reach the foramen ovale and gasserian ganglion, Kirschner⁵ in the 1930's placed a needle electrode into the region of the gasserian ganglion and used

diathermy heat to coagulate the ganglion and relieve the pain of trigeminal neuralgia.

Over the next twenty years the percutaneous diathermy method of treating tic pain became widespread in Europe. However, in 1951 Tonis³ reviewed and reported the complication rate of diathermy gasserian ganglion coagulation and found considerable morbidity despite tic pain relief. Chemical methods were tried by the same Hartel percutaneous route using alcohol¹, phenol in glycerin⁴, and boiling water.³ Despite pain relief from the chemical injections, the morbidity remained high. The main complications of both the diathermy and chemical methods included carotid artery injury, cranial nerve deficits and brain stem injuries all resulting from uncontrolled spread of diathermy current or chemicals.

From 1963 through 1970 Schurman⁶ in Germany used low milliamperage intermittent diathermy electrocoagulation of the gasserian ganglion and retrogasserian rootlets and achieved relief of tic pain in 93% of his patients with minimal complications and no mortality. Simultaneously, in the United States, Sweet and Wepsic⁷ utilized a radio frequency lesion generator to create a controlled retrogasserian lesion with similar results.

The procedure reported in this paper is essentially that initiated by Hartel's 1914 per-

Tic Procedure / SMITH

cutaneous approach and subsequent modifications of lesion generating devices since the 1930's. Sweet and Wepsic have developed the radio frequency technique used today for the relief of tic pain.

METHODS

The patient is given preoperative Innovar sedation and placed on a padded x-ray table in a comfortable supine position. Under Brevital anesthesia, a thin wall 18 gauge spinal needle is passed percutaneously from the cheek area into the foramen ovale and positioned adjacent to the clivus under fluoroscopic control. An electrode is passed through the needle and positioned relative to the clivus depending on the specific trigeminal division to be treated. A precisely controlled stimulus is produced with the patient awake. If the electrode is in the proper position, the appropriate division paresthesia is elicited. Additional Brevital is administered and the radio frequency lesion is created. Selective divisional hypalgesia is achieved with loss of pain sensation, but a degree of touch sensation is preserved. The entire procedure requires from 30 to 90 minutes to complete. The patient is usually ambulatory and able to eat postoperatively and often returns home the following day.

RESULTS

This paper reports eight patients who have undergone eleven electric tic procedures between July, 1974 and April, 1975 with no complications. Seven procedures were performed for tic pain while one was performed for intractable mandibular pain for recurrent carcinoma of the tonsil. The follow-up period has been short, but all eight individuals have re-

mained essentially free of pain. Two patients required repeat procedures because of recurrent tic pain immediately after surgery. Resolution of the pain was achieved with the repeated procedure.

DISCUSSION

The main advantage of the percutaneous procedure is that it offers pain relief with low morbidity and allows for precise lesion-placement in any one or more of the three trigeminal divisions. Utilizing graded and repeated lesions, the small, poorly-myelinated pain-conducting C fibers can be destroyed leaving the larger myelinated A and B fibers which conduct pressure, some touch, and motor impulses. Thus, the patient ideally achieves loss of tic pain with preservation of touch, position, and motor function to the jaw.

In all patients suffering from trigeminal neuralgia, initial medical management is indicated, consisting of a trial of Dilantin and/or Tegretol. If side-effects are excessive or if break-through pain occurs, then the patient becomes a candidate for an alcohol injection of the peripheral nerve at the supraorbital or infraorbital foramen. If mandibular tic pain is present or if the patient experiences recurrent first or second division pain after an alcohol block, then the electric tic procedure is indicated.

The percutaneous tic procedure has greatly reduced the need for craniotomy to control tic pain. The low morbidity of the method provides the possibility of repeating the procedure two or three times if necessary to achieve pain relief. In first division tic pain, the incidence of corneal anesthesia and subsequent ulceration is probably less with the percutaneous method as some degree of corneal sensation can be maintained.

SUMMARY

A safe, selective, low morbidity percutaneous method of treatment for trigeminal neuralgia has been introduced. The procedure does not replace initial medical management nor does it replace the office alcohol injection of the supraorbital or infraorbital nerves for first or second division pain. Although the follow-up period is relatively short in the eight cases presented, the results should be comparable to reported cases in the literature which achieve an

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approximate 90% incidence of tic pain relief.^{5 7} □

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Guidelines to Biopsy of the Breast

FRANK MCGREGOR, MD
ARTHUR F. HOGE, MD
JOE M. PARKER, MD

Because of widespread and extensive programs for early cancer detection, physicians in this state are, and will continue to be inundated with suspicious breast findings, many without a palpable mass. Diagnostic methods and approaches to biopsy are discussed.

In the past few months Oklahoma's physicians have experienced a surge in requests for breast examination because of the publicity given to two of our nation's most prominent women. This initial surge is only the beginning.

The Oklahoma Hospitals Breast Cancer Control Program (OHBCC), one of the twelve National Breast Cancer Demonstration Projects funded by the National Cancer Institute, has as one of its major goals improvement in detection and early diagnosis of breast cancer. A massive program designed to "teach" breast self-examination to women of Oklahoma over

the age of sixteen has been launched. At this time over 300 nurse-instructors have been trained. More than 9,000 women have examined mannequins containing palpable breast lumps and have learned to do self-examination with some confidence. The American Cancer Society has increased its lay education program for the coming year. All of this adds up to a surge of detection activity and, it is hoped, a marked increase in the discovery of early breast cancer.

Several hospitals in the state have established screening clinics and at least fifteen hospitals have thermographic, radiographic or xeroradiographic equipment, hereinafter referred to collectively as mammography.

During the coming year it is anticipated that some 6,000-8,000 women will present themselves to Oklahoma physicians with either a breast lump or an abnormal finding detected by screening center activities. These patients may or may not have a dominant tissue mass, nipple discharge, or skin changes suggesting the location of a tumor mass. Many cases will have none of these but only suspect calcific flecks visualized on mammography or perhaps a mass too small to be detected clinically.

Because of the anticipated increase in breast biopsies we have prepared a guide to promote efficiency in securing an accurate histologic diagnosis with minimal risks and costs and without harmful delay to the patient. Complete unanimity of opinion and technique concerning breast biopsy cannot be expected, but certain principles of surgical practice are gen-

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erally accepted and will be outlined and discussed briefly.

Specific surgical techniques will vary from surgeon to surgeon but preoccupation with techniques should not obscure the importance of obtaining adequate diagnostic tissue in a form that is adequate for diagnosis by the consulting pathologist.

INDICATIONS FOR BIOPSY

1. Palpable mass.

The presence of a clinically palpable mass not attributable to anatomic variation or physiologic change is the primary indication for biopsy. With careful attention to breast contour and consistency of a side-to-side comparison, the experienced physician will learn to distinguish the gross cyst amenable to aspiration from the solid mass requiring biopsy. Specific stigmata of cancers, such as skin dimpling or nipple retraction may further augment the indication for biopsy.

2. Gross cysts.

The finding of a smooth, ovoid or speherical mass, movable, firm or fluctuant, is an adequate indication for attempted aspiration. This procedure can permit immediate differentiation of gross cysts and solid tumor. Accepted practice requires open biopsy for masses not completely decompressed by aspiration, for recurrent cysts, and upon aspiration of bloody fluid.

3. Nipple discharge.

Spontaneous nipple drainage from non-lactating breasts is an indication for cytologic study even though the "false-negative" rate may be high. Lactation may occur in non-puerperal states and the cause should be ascertained. Non-lactating nipple drainage should be investigated by a careful examination and location of the duct system involved, mammography, and possibly thermography. In the absence of a palpable mass or mammographic localization of suspect areas, total major duct excision may be necessary. Pink or frankly bloody discharge, particularly in the presence of a mass, is an absolute indication for surgery with removal of the major duct system involved.

4. Non-palpable lesions.

Becoming increasingly common today is the finding of an abnormal pattern on mammography in the absence of a palpable mass. If these areas contain any of the stigmata characteristic of malignancy (a stellate or irregular mass, abnormal calcification, skin thickening),

there is very high percentage correlation with positive histologic diagnosis. Suspicious lesions other than characteristic stigmata should lead to repeat mammography and screening at three months.

5. Eczematoid changes of the nipple or areola.

Chronic irritative or ulcerative skin changes of the nipple or areola suggestive of Paget's disease should be considered an indication for mammography. In the absence of a palpable mass or mammographic abnormality the nipple or areola should be biopsied. If evidence of underlying changes in the duct system is present, the biopsy of the skin should be accompanied by extensive biopsy of the duct system in question.

6. Axillary adenopathy.

Occult breast cancer should be considered as a possible cause of any significant axillary node enlargement. After careful evaluation for other causes, including metastatic cancer from more distant sites, biopsy of the node may be necessary to determine an accurate diagnosis.

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Mammography should be done prior to the node biopsy. Normal mammograms do not rule out the existence of an occult breast cancer.

GENERAL RULES

Representative tissue from all suspected lesions should be obtained. This may include all of a small lesion or a part of a large lesion. If the original specimen does not reflect the findings of either physical examination or mammography, additional tissue should be obtained.

Non-invasive mammography should be performed on all patients with palpable masses which are suspected of being malignant in order to identify other non-palpable lesions. This is particularly true in those patients who are at high risk for cancer. If the mammographic findings are suggestive or diagnostic of malignancy, one should consider doing all metastatic surveys prior to subjecting the patient to a biopsy and immediate radical mastectomy, as a significant number of patients will have metastatic disease at that time.

Specimen Radiography: All specimens in which abnormal calcifications or other mammographic evidence of disease is the only indication for biopsy should be submitted to radiography prior to examination by the pathologist. If the specimen-radiography does not reveal the findings noted on mammography further tissue removal should be done. The pathologist should have both the specimen-radiography and the mammogram prior to sectioning and blocking the specimen.

BIOPSY METHODS

1. Needle aspiration of the cyst.

Aspiration of a clinically-suspected cyst may be undertaken in an out-patient setting using local anesthesia. Stabilizing the mass between the fingers of one hand, the operator may insert a #20 or a #21 gauge needle for aspiration of the cyst fluid. If a larger needle is used, it may be necessary to puncture the skin with a sharp pointed scalpel blade to facilitate insertion of the needle. Cytologic analysis of the cyst fluid should be obtained but is not a reliable indication of malignant change within the breast except in the unusual occurrence of an intracystic carcinoma. The presence of bloody fluid, even

in the absence of equivocal cytologic findings, is an indication for open biopsy. A residual mass lesion after aspiration, and recurrent cysts are also indications for open biopsy.

2. Biopsy of solid masses.

Needle aspiration of a solid mass can be done in an out-patient setting but is not generally recommended except to confirm obvious cancer. A "negative" needle biopsy should not be interpreted as anything but an indication for open biopsy. One established method involves use of a #18 needle attached to a 10 cc or 20 cc syringe. After insertion of the needle into the mass, suction is applied to the syringe as it is advanced and retracted frequently enough to dislodge and mince a small amount of tissue for removal. Macerated tissue thus removed within the needle or syringe is placed on slides for smears or in a fixative fluid for histologic sections. Alternately, a biopsy needle such as the Vim-Silverman needle can be used to obtain tissue for histologic study. *In any method of needle biopsy, the diagnosis of a non-malignant lesion cannot be accepted as the final diagnosis.* Despite the possibility of not establishing a diagnosis of malignant disease in some instances, needle biopsy is a valuable aid, particularly in the inoperable patient who is to receive some sort of palliative therapy. If undertaking needle biopsy in a setting where the method is not frequently used, the surgeon should discuss the form of material and preferred fixative with the pathologist beforehand.

3. Incisional biopsy.

In the operating room under local or general anesthesia, large tumors can be biopsied by removing a small wedge for frozen or permanent section. This is a preferred technique for large tumors to avoid undue disruption of the breast, while tumors less than three cm in diameter may be completely removed without difficulty. If the diagnosis is suggestive of in-situ cancer or well differentiated tubular carcinoma, definitive therapy should be postponed until a thorough study has been made with permanent sections. If the frozen section diagnosis is undifferentiated carcinoma, the surgeon would be well advised to postpone definitive therapy until a metastatic survey has been completed. If the frozen section diagnosis is that of invasive ductal carcinoma, the decision as to definitive surgery under the same anesthetic should be made by the surgeon. If the lesion is large, if any of the grave signs of

malignancy are noted, or if the nodes are thought to be clinically malignant, it may be advisable to postpone surgery until metastatic surveys have been completed.

4. Excisional biopsy.

Under this general heading are included segmental and quadrant biopsies undertaken for small masses, usually less than three cm in size. The type of skin incision may vary as a matter of personal preference, but most surgeons feel that a circumferential incision leaves a more cosmetic scar. Following exposure of the glandular surface of the breast, the peripheral edge of the specimen to be removed is mobilized and elevated from the underlying chest wall. Using this maneuver, the surgeon may then palpate both the deep and superficial surfaces of the gland simultaneously, facilitating the localization of small or elusive lesions. Even with a lesion thought to be benign, adjacent tissue should be included for better assessment of the normal breast. With non-palpable lesions found on mammography, a wide segmental biopsy may be necessary to assure inclusion of the lesion, since the radiologist's localization of the lesion may be altered by the patient's position on the operating table. In time, other methods of localization such as insertion of needles with the aid of fluoroscopy and mammography may reduce the need for wide excision to assure removal of such lesions.

A small lesion that is centrally located may be excised through a circum-areolar incision. Deep V-shaped incisions encompassing the mass may be closed in layers to re-establish contour and to allow an adequate base for the overlying areola. Such an incision may be used for major duct system excision. In all breast excisional biopsies, particularly those for small lesions, subcutaneous fat can be preserved on the skin flaps to facilitate later closure. With approximation of breast tissue in several layers and careful placement of the thick skin flaps, normal breast contour should be established. In large excisions the breast size may be reduced but breast contour should not be distorted.

The tremendous interest in cancer and particularly that focused on breast malignancies can be very rewarding if this interest can be directed toward earlier diagnosis. The activities of the Breast Cancer Control Network, the Breast Cancer Screening Centers, and the American Cancer Society are causing a marked increase in the number of women seeking physician guidance. We hope this guide will help physicians determine the indications for biopsy and logical procedural steps. □

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Congenital Anomalies In Infants And Children, 1875

RONALD D. GREENWOOD, MD

In 1875, the diagnosis and treatment of congenital anomalies was very limited. Knowledge in this area and descriptions from a century ago are reviewed.

One hundred years ago the outlook for the infant born with congenital anomalies or for the child with congenital disease was bleak indeed. In the ensuing century, the developments in this area have been particularly rapid. In 1875, pediatrics was in its infancy, Virchow's *Cellular Pathology* (1858) and Darwin's *Origin of the Species* (1859) were new on the scene. There were only a dozen hospitals in this country devoted solely to the care of children. Abraham Jacobi (1830-1919) had come to New York in 1853 and was serving in a pediatric post (1860) at the New York Medical College. Thomas Morgan Rotch (1849-1914) had graduated from Harvard just one year before and would 13 years later (1888) hold the first Professorship of Pediatrics at Harvard. Luther

Emmet Holt and Issac Arthur Abt, giants in American Pediatrics, were very young men. O'Dwyer, likewise, was working in New York but had not yet performed intubation. In England, Charles West (1816-98) had established the Children's Hospital at Great Ormond Street in London and resigned in 1875. Henri Louis Roger (1809-91), Ernest Bouchet (1818-91), and Marie-Jules Parrot (1839-83) were practicing medicine in France. In another European center, Henoch (1820-1910) had recently described the infantile purpura; Otto Soltmann, Alois Bednar, Carl Hennig, Alfred Vogel, Johann H. Rehn, Carl Gerhardt, Johann T. A. Steffen, Phillip Biedect, and others were current practitioners of medicine for children.

Infants and children with congenital anomalies were usually felt to be untreatable. Ether had been introduced only 30 years before at the Massachusetts General Hospital on October 16, 1846, and aseptic surgery was in its infancy. Medical therapy was likewise very primitive.

In 1875, the malformations known were markedly fewer in number than today but most gross major system anomalies were known. Only a few of the syndromes or patterns of malformations today known by their eponyms were noted by 1875 (Table 1). Also noted were: congenital epulis (noted in 1871) is sometimes called Neumann Syndrome after Ernst Neumann (1843-1918); Prune Belly Syndrome was first noted in 1839 by F. Froh-

The Children's Hospital Medical Center and Department of Pediatrics, Harvard Medical School, Boston, Massachusetts

lich but is only rarely associated with his name; cleft lip, palate, fistula of lower lip and progeria facies were noted in 1845 and 1862 by Jean N. Demarquay (1811-1875) and Didier Dominique Alfred Richet (1816-1891) respectively, but Demarquay-Richet Syndrome has only rarely been used.

We shall consider the descriptions in 1875 of a few of the more serious congenital malformations.

Gross malformations of the body in general, "double monsters" or "attached fetal remains" were usually not treatable. Some forms were amenable to surgery. As Holmes reported:

No difficulty of diagnosis can exist in the case of the attached parasite. The advantages and the feasibility of removing it from the body to which it is appended will depend in a great measure upon the place and extent of its attachment, and partly upon the nature of the parasite itself.

Imperforate Anus (described by Holmes):

Imperforate rectum is a deformity which,

though sufficiently rare to prevent most practitioners from having much individual experience of it, is yet common enough to cost the lives of many children every year . . .

Cases of imperforate rectum may be divided into two classes, vis. those in which no anus exists (imperforate anus properly so called) and those in which there is an anus leading into a cul-de-sac (imperforate rectum) . . .

Membranous imperforate anus was amenable to surgical intervention.

When bulging is perceived, all that is necessary is to make an incision of sufficient size in the situation of the natural anus, and give exit to the contents of the gut.

When there was complete or partial absence of the rectum, surgery was far more difficult.

When no bulging is perceived, after waiting for a reasonable time, it is probable that the lower end of the rectum is deficient. In such a case, if the external parts exhibit no obvious malformation, an exploratory operation should be performed, the object of which is to discover the end of the rectum, and if possible

Table 1
CONGENITAL SYNDROMES OR ANOMALIES KNOWN
IN 1875 WHICH TODAY ARE RECOGNIZED BY THE NAMES OF THEIR DISCOVERER

Vincent Alexander Bochdalek (1801-1883)	Left Congenital Diaphragmatic Hernia	1848
Giovanni Battista Morgagni (1682-1771)	Anterior Diaphragmatic Hernia	1761
John Langdon Haydon Down (1828-1896)	Mongolism	1866
Guillaume Benjamin Amand Duchenne (1806-1875)	Muscular Dystrophy	1868
Wilhelm Heinrich Erb (1840-1921)	Upper Arm Paralysis	1874*
Wilhelm Ebstein (1836-1912)	Downward Displacement of Tricuspid Valve	1866
Nicolaus Friedreich (1825-1882)	Friedreich's Ataxia	1863
Gustav Scheuthauer (1832-1894)	Cleidocranial Dysostosis	1871
John Zachariah Laurence (1830-1874)	Laurence Moon Biedl Syndrome	1866
Moritz Heinrich von Romberg (1795-1873)	Facial Hemiatrophy	1846
Ernst Munchmeyer (1846-1880)	Myositis Ossificans	1869

*Also described by Duchenne in 1875

Anomalies / GREENWOOD

to draw it down, and attach it to the skin in the situation of the anus.

Patients with fistulae, especially, to the vagina, often were spared surgery. Holmes notes one patient:

. . . woman was discovered on rectal examination to have imperforate anus, the rectum opening obliquely into the back of the vagina. In this case, the command over the feces was so perfect that no inconvenience resulted; and neither she, nor her husband, nor the accoucheur who had delivered her three times were aware that there was any peculiarity about the sexual organs. Such cases as these should not be interfered with.

GASTROINTESTINAL OBSTRUCTION

Congenital obstruction elsewhere in the gastrointestinal tract was a most serious problem.

Colotomy in congenital obstructions of the lower bowel: When the rectum is entirely deficient, the only means of preserving life is to open some higher part of the bowel.

Obstruction of the small intestine was recognized clinically but much less frequently. Surgery was often attempted but as Holmes noted "little hope can be entertained of good from anything."

Spina bifida was a severe anomaly. Chausier determined that it occurred once in one thousand births.

Spina Bifida was rarely seen at the Children's Hospital in Boston. Treatment was unsatisfactory. A shield was constructed to "relieve pressure and prevent chafing, unless the meningocele will inevitably rupture."

Vogel noted:

Surgeons have tried countless varieties of methods with the hope of bringing about a diminution of the tumor and closure of the spinal canal. The almost invariable failure of all surgical procedures is due to the fact that the inner wall of the sac is formed by the spinal membrane and that any injury of this membrane is apt to produce meningitis which cannot be limited to the sac. The tumor has been repeatedly punctured with exploring trocars and pierced with needles often forming valvular openings in the integument. Lately Gaupp presented a boy seven years old, who had a hydrorachis the size of a child's head, which he had cured in the first few weeks of infantile life by puncturing it eight times. After the

first puncture, the fissure of the vertebrae could be distinctly felt, but the gap rapidly diminished, and finally closure took place in ten weeks. All the parts constituting the vertebrae are now present in this boy, but the spinous processes are somewhat flattened. Excision, with the subsequent use of compression by quills or small wooden rods, has been tried. Chassaignac treated these cases by puncture and injecting iodine, as in a hydrocele, and the pediculated variety has been tied off. Finally, constant steady pressure upon the tumor by a hair pillow has been tried, but, although this method caused great pain and convulsive twitchings, it did not effect a single cure. All experimenters have been obliged to acknowledge that their efforts have failed, now still more, that meningitic symptoms, which are always followed by death, came on immediately after the operation. Though the prognosis of hydrorachis is at best very unfavorable, most children dying even without operation, still, owing to the rarity of this condition, statistics upon this point are scarce, and it is therefore difficult to determine which of the two courses it is best to pursue. The most rational treatment . . . is to protect the sac from all kinds of injury and pressure, by a soft, cup shaped pad which will only rest upon its margin, and which is secured to the body by elastic straps. If the hydrorachis is complicated with congenital hydrocephalus, as is frequently the case, then no other means should be adopted than that just described, for every diminution and compression of the tumor causes tension within the head.

CLEFT LIP AND PALATE

Vogel described this anomaly:

Harelip is a congenital splitting of the upper lip; cleft palate, a congenital fissure of the hard palate . . . Nothing but an operation can remedy this deformity. As regards the time when it is to be performed, much has already been written and disputed . . . At all events, however, the operation should be performed before the eruption of the teeth, for, as soon as dentition has once begun, children are oftener

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subject to sickness, and on that account the result often proves a failure. Moreover, children more than six months old begin to use their hands, with which they may tear down the plaster after the operation, or entangle them among the points of the pins, and thus frustrate its success.

Surgical details for those lesions amenable to surgery are not discussed, but we should briefly look at the approach to cleft lip to have a feeling for surgical methods.

Before the operation, the child is to be kept awake for several hours, in order that it may subsequently fall into a deeper sleep than usual; and it is also to be nursed so that thirst or hunger may not rouse it too soon. It is best to wrap the entire body up to the neck in a sheet, and then place it in the lap of an assistant. Nothing more is necessary for the operation than a sharp tenaculum, strong sharp scissors, the sewing apparatus, and a few strips of adhesive plaster. A second assistant now seizes a part of the split lip between his thumb and index-finger and compresses the vessels. The operator, seated opposite the child, seizes hold of the border of the lip with the tenaculum where it passes over into the fissure upwardly, pushes the scissors into the slit, and with one cut removes the entire edge. The same maneuvers are repeated on the other side. After the edges have been adjusted, two or three needles, the lower ones first, are introduced, and a few turns of the ligature taken around each one of them.

Renal anomalies were often well tolerated and thus not discovered.

Vogel reported:

The kidneys are never totally absent; even in the most incomplete abortions they may be detected in some form. One kidney only is to be found in some cases, in which condition Rokitansky makes a distinction between the single and the simple. In the former, a single kidney is found at the normal place, to the right or left side of the vertebrae column, differing in shape but little from the ordinary

kidney, while on the opposite side there is no trace of a gland. The simple kidney, on the other hand, is an abnormal fusion of the two kidneys, the most common form of which is the horseshoe kidney.

Genitourinary anomalies: Hypospadias and epispadias were well understood and surgery was not considered. Exstrophy, however, was a more severe anomaly. Vogel describes the situation:

In all instances the patients afflicted with it generate a disgusting urinary odor and suffer from constant excoriations around the openings of the ureters . . . There is nothing in these deformities incompatible with life and cases are known where the persons attained an age of even forty years. Indeed, Huxam describes the very remarkable case of a woman who, afflicted with this prolapsus vesicae congenitus and cloacae married in her twenty-third year, conceived, and gave birth to children. The husband of such a creature deserves almost as much admiration as herself.

Malformations such as congenital heart disease, omphalocele, esophageal atresia, and congenital diaphragmatic hernia were serious anomalies that were also recognized but were not amenable to intervention. □

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Intrauterine Infection, 1808

RONALD D. GREENWOOD, MD

At one of the early meetings of the Medical and Chirurgical Society of London, Doctor Edward Jenner related an instance of smallpox in the newborn of a newly vaccinated woman. This is probably the earliest case of fetal infection due to maternal treatment

In 1805, a few physicians and surgeons in London met for the purpose of forming a society "founded upon liberal and independent principles, and conducted with the propriety and dignity which are worthy of the medical profession." The result was the Medical and Chirurgical Society of London. Members included John Abernathy, Matthew Baillie, Humphrey Davey, John Richard Farre, John Hunter, Edward Jenner and John Sims. Many other prominent physicians were members. In 1809, the council President was Matthew Baillie. In that year the first volume *Medico-Chirurgical Transactions* appeared; these were the papers read at meetings of this society.

At such a meeting on April 4, 1809, Edward Jenner read a paper entitled "The Cases of Small-Pox Infection communicated to the

Foetus in Utero Under Peculiar Circumstances with Additional Remarks."

This included a most interesting medical discovery although it was poorly understood at the time. Jenner relates a case of Mr. Henry Gervis, a surgeon at Ashburton in Devonshire.

The smallpox having appeared in the Village of Woolson Green, about three miles from Ashburton, on the 6th of May, 1808, I vaccinated a poor woman . . . who was in the last month of her pregnancy. Her three children had been inoculated the preceding day with variolous matter . . . I made two punctures in each arm, each of which fortunately succeeded, and they regularly passed the disorder, complaining only on the tenth and eleventh day, when the areola was most extended as is usual. I saw her very frequently during the progress of her disorder, and once or twice after its complete termination: I therefore can speak positively, that during that time she laboured under no symptom but what is connected with the cowpox. From this period she continued perfectly well, and on Saturday last the 11th instant, she was delivered of a female child, having at the time of its birth many eruptions on it, bearing much the appearance of small-pox in the early stage of the disease. This even happened five weeks after her vaccination, and one

month after she had been exposed to the variolous infection of her own three children, and that of several other persons in the same village. On the 14th I visited the child again, when I found the eruptions had increased to some thousands, perfectly distinct, and their character well marked . . . on the 18th the infant was

seized with slight convulsions, and on the morning of the 19th it expired.

In addition to the circumstance of the mother's conveying the variolous infection to her unborn child, without feeling any indisposition from its action on her own constitution, I must remark that there cannot be a stronger proof of the efficacy of vaccine inoculation than this case affords.

Since his graduation from the Northwestern University Medical School in 1969, Ronald D. Greenwood, MD, has been certified by the American Board of Pediatrics. His practice is limited to his specialty, pediatric cardiology. In addition, he is affiliated with the Departments of Pediatrics and Anatomy at Harvard Medical School. He is a member of the American Academy of Pediatrics and the American Association for the History of Medicine.

ACKNOWLEDGEMENT

I am indebted to the Francis A. Countway Library of Medicine Harvard Medical School for use of historical materials.

REFERENCE

Jenner, E.: Two Cases of Small-Pox Infection Communicated to the Foetus in Utero Under Peculiar Circumstances with Additional Remarks. *Medico-Chirurgical Transactions* 1:269-275, 1809.

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The guest lecturer will be Borys Surawicz, MD, Professor of Medicine, University of Kentucky College of Medicine, Lexington, Kentucky.

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The sixth annual Aspen Radiology Conference will be held March 1st-5th, 1976, at the Aspen Institute for Humanistic Studies, Aspen, Colorado. The conference is designed for physicians and scientists interested in diagnostic radiology, nuclear medicine and radiation therapy and will explore the impact of clinical and technological advances on radiologic practice.

The topics for discussions will include advances in cardiovascular, gastrointestinal, bone and neuroradiology involving a tri-radiological approach. Each morning will survey the advances in a single radiology subdivision as a refresher course with independent parallel diagnostic, nuclear medicine and therapy sessions. Instructive cases, illustrating these topics and previewed by the audience, will be presented for open discussion in the afternoons.

Further information may be obtained from Emanuel Salzman, MD, Conference Chairman, Division of Radiology, Beth Israel Hospital, Denver, Colorado 80204.

IMPORTANT INFORMATION: This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or Narcan® (naloxone HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with special caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis. In severe dehydration or electrolyte imbalance, withhold Lomotil until corrective therapy has been initiated.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage. Use with care in patients with acute ulcerative colitis and discontinue use if abdominal distention or other symptoms develop.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing, hyperthermia, tachycardia and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria, paralytic ileus, and toxic megacolon.

Dosage and administration: Lomotil is contraindicated in children less than 2 years old. Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, hyperthermia, tachycardia, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. A narcotic antagonist may be used in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. Liquid, 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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The Cost of Hospitalization— Oklahoma Hospitals

JAMES E. PERRY, MBA

Given the increasing cost of hospitalization, Oklahoma hospitals exhibit a wide range of operating characteristics.

Within the United States, significant concern has been expressed with respect to the rising costs of goods and services in many sectors of the economy. One area of concern which has received considerable attention to date, and will apparently continue to receive attention in the foreseeable future, is our health care delivery system.

The health care industry in the United States has grown continuously, to the point, whereby hospital expenditures alone in recent years have accounted for more than 2.8% of the Gross National Product.¹ Whereas hospital related expenditures totaled \$12.0 billion in 1964, by the end of 1973 this figure had risen to \$36.3 billion, an increase of over 300%.² As greater amounts of money are expended in the delivery of health care, pressures, too, for cost

control and institutional efficiency on the one hand, and the development of alternative methods of delivery, on the other hand, have arisen. While the cost of hospitalization is only a component part of the total cost of health care, albeit large, a review of the operational characteristics of hospitals, focusing primarily on the overall per diem cost of hospitalization illustrates the significance of the health problem facing the nation today.

HOSPITAL SERVICE CHARACTERISTICS

Latest information compiled and released by the American Hospital Association indicates that in the state of Oklahoma there are 145 hospitals with a total of 17,789 available beds.³ These hospitals had an average occupancy rate of 72.5%, accounted for 477,833 admissions, 4,707,950 inpatient days of care, and over 2.3 million outpatient occasions of service.⁴ A complete breakdown of hospitals, beds, admissions, occupancy, inpatient days, and outpatient visits, by hospital bed size and hospital type is presented in Tables 1 and 2 respectively.

While the 125 hospitals with an average bed size of less than 199 beds control 44.5% of the total beds available and account for 58.8% of all admissions, they account for only 39.4% of

TABLE 1
State of Oklahoma
Hospitals, Beds, Admissions, Occupancy, Inpatient Days,
Outpatient Visits by Hospital Bed Size

Classi- fication	Hospitals	Beds	Admissions	Occupancy	Inpatient Days	Outpatient Visits
6 -24 beds	10	202	5,780	47.0	35,528	16,774
25 -49 beds	50	1,723	53,840	56.2	352,792	330,245
50 -99 beds	45	2,973	101,454	61.4	667,131	588,164
100-199 beds	20	3,011	120,111	72.8	799,845	251,790
200-299 beds	8	1,951	55,805	74.3	528,762	646,669
300-399 beds	2	692	23,768	79.6	201,330	56,310
400-499 beds	2	892	23,807	77.6	252,599	231,379
500 & over	8	6,345	93,268	80.8	1,869,963	234,922
Total	145	17,789	477,833	72.5 ¹	4,707,950	2,356,253

¹Weighted Average

Source: American Hospital Association, *Hospital Statistics 1974 Edition*
(Chicago, Illinois, 1974), p. 128.

all inpatient days and 50.4% of outpatient visits. The remaining 20 hospitals with an average bed size greater than 200 beds control 54.6% of total inpatient days and 49.6% of outpatient occasions of service. In fact the eight largest hospitals account for almost 40% of total inpatient days. These same hospitals account for approximately 10% of outpatient visits, thus bearing out the expectation that the largest hospitals, located within metropolitan areas, possessing sophisticated labor and capital intensification, generally, but certainly not

exclusively, respond to the more acute illnesses, necessitating longer periods of hospitalization. Furthermore, their outpatient activity derives basically from the fundamental responsibility to offer a full range of medical service to the community, rather than a conscious effort to cultivate this aspect of the health care market.

HOSPITAL OPERATING CHARACTERISTICS

While hospital service characteristics, as

TABLE 2
State of Oklahoma
Hospitals, Beds, Admissions, Occupancy, Inpatient Days,
Outpatient Visits by Hospital Type

Type	Hospitals	Beds	Admissions	Occupancy	Inpatient Days	Outpatient Visits
Psychiatric	7	4,248	10,447	81.4	1,262,538	73,128
Tuberculosis & Other Resp.	1	150	347	51.3	28,144	1,058
Maternity	1	12	125	16.7	871	667
Rehabilitation	1	77	578	93.5	26,278	253
Orthopedic	1	74	2,625	82.4	22,277	6,803
Chronic	1	231	1,054	83.5	70,450	689
General	133	12,997	462,657	69.5	3,297,395	2,273,655
Total	145	17,789	477,833	72.5 ¹	4,707,950	2,356,253

¹Weighted Average

Source: American Hospital Association, *Hospital Statistics 1974 Edition*
(Chicago, Illinois, 1974), p. 128.

TABLE 3
Oklahoma Community Hospitals
As A Per Cent of State Hospital Population
by Hospital Bed Size

Classification	All Oklahoma Hospitals	Community Hospitals	Community Hospitals Per Cent To Total
6 - 24 beds	10	9	90.0
25 - 49 beds	50	44	88.0
50 - 99 beds	45	36	80.0
100-199 beds	20	19	95.0
200-299 beds	8	4	50.0
300-399 beds	2	2	100.0
400-499 beds	2	1	50.0
500 & over	8	4	50.0
Total	145	119	82.1

Source: American Hospital Association, *Hospital Statistics 1974 Edition* (Chicago, Illinois, 1974), p. 128.

cited above, shed light on the magnitude of the health care delivery system in Oklahoma, a review of the operational characteristics of Oklahoma hospitals serves to focus on the cost significance of the health care process. For the purposes of this study the operational characteristics of community hospitals, which account for 82.1% of the Oklahoma hospital population will be examined. (Table 3)⁵

Within the population of 119 community hospitals in Oklahoma the average number of employees per bed is 2.2. (Table 4)⁶ Hospitals with a bed size from 25 to 49 beds have the lowest number of employees per bed, namely 1.59, while the one Oklahoma community hospital with bed size in the 400-499 range has an employee per bed ratio of 2.81. Interestingly, the larger hospitals with average bed sizes above 200 beds, have a ratio of employees per

TABLE 4
Operational Characteristics of
Oklahoma Community Hospitals

Classification	Hospitals	Employees Per Bed	Overall Per Diem Cost	Labor Intensity
6 - 24 beds	9	1.74	\$ 78.47	.545
25 - 49 beds	44	1.59	66.74	.525
50 - 99 beds	36	1.80	75.89	.527
100-199 beds	19	2.31	86.19	.531
200-299 beds	4	2.21	83.95	.540
300-399 beds	2	2.56	78.85	.543
400-499 beds	1	2.81	117.75	.547
500 & over	4	2.68	106.87	.527
Total	119	2.20 ¹	\$ 87.34	.531

¹Weighted Average

bed which varies from a low of 2.21 to a high of 2.81.

Equally interesting, while these larger hospitals spend in the area of 54% of each dollar for labor, their overall per diem cost of hospitalization ranges from \$78.85 to \$117.75 per equivalent inpatient day.⁷ The overall per diem cost of hospitalization for all Oklahoma community hospitals ranges from a low of \$66.74 per equivalent inpatient day to \$117.75. Part of the variation in the per diem cost of hospitalization can be explained by the age and size of investment in plant and capital assets. This fact notwithstanding, the general level of the cost of hospitalization might be ascribed in large measure to technological advancements, seen for example in the greater cost of diagnostic and treatment equipment, greater demand for and specialization within skilled labor, accompanied by such things as unionization and even occupational wage differentials created by rising minimum wage rates.⁸

WHAT HAS BEEN DONE

As a consequence of the high cost of medical care today, we see greater government involvement in the health industry, increased interest in developing alternative methods of health care delivery, and concentrated efforts on the part of hospital administrators to control costs.⁹

In some quarters medical care is not viewed as an economic issue but rather as a social right. "As a consequence . . . the traditional contract between the medical profession and society is being renegotiated with prepayment providing the leverage to new terms that are much closer to the public's emerging health care aspirations than to the profession's customary views."¹⁰ In consonance with this point of view government backed programs such as Medicare were implemented in mid 1966, and

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today significant efforts aimed at developing and implementing a national health insurance program are being made.

Within the health industry tremendous advances have been made with respect to service sharing and the development of management systems for the purposes of cutting and/or controlling costs. For the most part, management systems programs center on the establishment of institutional goals, financial plans and budgets, manpower budgets, and evaluation programs for the same, all constructed with an eye toward rendering quality care at reasonable cost.¹¹ Service-sharing has been implemented both in terms of treatment equipment and the support functions, such as credit and collections, printing and laundry.¹²

Other vehicles for cost containment which have received consideration concern a shift of emphasis from academically-trained personnel to acquired skill personnel for health industry support positions and the development of ambulatory surgery.¹³

Most notably, the military forces have been cited as a potential major supplier of persons with acquired skills.¹⁴ Such an increased supply of labor in middle level support positions would have a dampening effect on labor cost within the industry. So too, the development of ambulatory surgery, which although innovative, has the potential of contributing to cost control through decreased hospital utilization.

In summary, the health care delivery system in the United States is very costly and has grown in magnitude for many years. To the extent that the health system continues to grow and the cost of medical services continues to rise, pressures from within and outside the industry have also increased for cost control and institutional efficiency. These pressures

have taken form in a greater emphasis on the development of management planning and evaluation systems, but have also been accompanied by greater governmental involvement. □

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2. American Hospital Association, "The Nation's Hospitals: A Statistical Profile," *Hospital Statistics 1974 Edition* (Chicago, Illinois: American Hospital Association, 1974), p. 6.
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4. American Hospital Association, "The Nation's Hospitals: A Statistical Profile," *Hospital Statistics 1974 Edition* (Chicago, Illinois: American Hospital Association, 1974), p. 128.
5. Community Hospitals are nonfederal, short term general; maternity; eye, ear, nose, and throat; children's; orthopedic; chronic; and other special hospitals other than psychiatric and tuberculosis.
6. Calculations include the number of persons on payroll at close of reporting period for American Hospital Association annual survey purposes (Sept. 30, 1973): includes full-time equivalents of part time personnel but excludes trainees, private nurses, and volunteers. Full time equivalents were calculated on the basis that two part-time persons equal one full-time person.
7. Equivalent Inpatient Day is an aggregate figure reflecting the number of days of inpatient care plus an estimate of the volume of outpatient services, expressed in units equivalent to an inpatient day in level of effort. Derived by multiplying number of outpatient visits by the ratio of outpatient revenue per outpatient visit to inpatient revenue per inpatient day, producing the number of adjusted patient days attributable to outpatient services. The number of inpatient days plus the number of adjusted patient days equals the inpatient day equivalent.
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Oklahoma City University, Oklahoma City,
Oklahoma.

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News From The Oklahoma State Department of Health

A workable communicable disease surveillance system is now available to the physicians of Oklahoma. The role of the local health department is expanded under this new system. The objective is to simplify the reporting of those diseases that affect the general health of all the people. All physicians and public health officials obviously realize the need to respond quickly and appropriately to communicable diseases.

The local health department is responsible for distributing and collecting the cards and forwarding the *information* to the Epidemiology Division of the State Health Department. The cards are to remain on file for a six-month period in the local health department. The cards require no postage and are self addressed to simplify handling. Physicians are reminded that they are required by law to report the communicable diseases listed on the card. Failure or refusal to report these diseases shall constitute a misdemeanor. ☐

Oklahoma State Department of Health
Weekly Communicable Disease Report

1.

The following diseases should be reported immediately by telephone to your local county health department.*

Botulism	Pertussis	Smallpox
Cholera	Plague	Syphilis
Diphtheria	Poliomyelitis	Tetanus
Encephalitis	Rabies (Man or Animal)	Trichinosis
Food Poisoning	Relapsing Fever	Tuberculosis
Gonorrhea	Rocky Mountain Spotted Fever	Typhoid Fever
Hepatitis B	Rubella	Typhus Fever
Malaria	Rubella, Congenital Syndrome	Yellow Fever
Meningococcal Infections	Rubeola	Unusual Syndromes and Outbreaks

2.

Report by Number of Cases Only:

Actinomycosis	_____	Hepatitis A	_____	Psittacosis	_____
Amebiasis	_____	Hepatitis (Unspecified)	_____	Rheumatic	_____
Anthrax	_____	Histoplasmosis	_____	Fever (Acute)	_____
Aseptic Meningitis	_____	Influenza Syndrome	_____	Salmonellosis	_____
Blastomycosis	_____	Leprosy	_____	Shigellosis	_____
Brucellosis	_____	Leptospirosis	_____	Toxoplasmosis	_____
Chickenpox (Varicella)	_____	Lymphogranuloma Venereum	_____	Tularemia	_____
Coccidioidomycosis	_____	Mumps	_____		

Report should be mailed each Friday unless Friday is an official holiday, in which case the report should be mailed on the last working day of the week.

*Should you not be able to reach your county health department, (i.e., nights and week-ends) call the State Epidemiologist in Oklahoma City, (405) 271-4060. (Toll Free)

Your reporting is critically important to the disease control efforts of your health department. The few minutes per week required in completing this form are appreciated. *Thank You!*

☐ Check here if you need more cards.

Physician's Name _____

Date Report Submitted _____

The Oklahoma Public Health Code, 1963, Article 5, paragraphs 1-502 and 1-503 and the State Board of Health regulations adopted December 8, 1968, require that practicing physicians, clinical laboratories, hospitals, penal and charitable institutions report these communicable diseases as listed. Failure or refusal to report diseases as required by the Board shall constitute a misdemeanor.

ODH Form No. 295/Rev. 1975

COMMUNICABLE DISEASES IN OKLAHOMA FOR SEPTEMBER, 1975

DISEASE	September 1975	September 1974	August 1975	Total To Date	
				1975	1974
Amebiasis	3	2	6	25	22
Brucellosis	—	2	—	3	7
Chickenpox	10	10	6	960	816
Encephalitis, Infectious	7	3	7	45	40
Gonorrhea (Use Form ODH-228)	1251	1020	1324	9826	8411
Hepatitis, A, B, Unspecified	87	58	40	627	771
Leptospirosis	—	—	—	—	1
Malaria	1	—	—	2	3
Meningococcal Infections	—	—	—	9	15
Meningitis, Aseptic	16	10	12	64	55
Mumps	10	3	10	193	372
Rabies in Animals	11	14	5	88	126
Rheumatic Fever	—	2	—	7	11
Rocky Mountain Spotted Fever	14	5	5	86	58
Rubella	—	3	3	85	55
Rubella, Congenital Syndrome	—	—	—	1	1
Rubeola	6	2	—	132	27
Salmonellosis	44	31	41	187	203
Shigellosis	31	30	42	269	138
Syphilis, Infectious (Use Form ODH-228)	6	16	12	65	109
Tetanus	—	—	—	—	1
Tuberculosis, New Active	17	11	29	238	227
Tularemia	9	1	3	9	14
Typhoid Fever	—	—	—	—	2
Whooping Cough	2	2	2	23	16

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	Starting Dosage	Increased Monthly by	Usual Maintenance	Maximal Recommended
Adult Hypercholesterolemic	1.0-2.0 mg.	1.0-2.0 mg.	4.0-8.0 mg.	4.0-8.0 mg.
Pediatric Hypercholesterolemic	0.05 mg./kg. body weight	0.05 mg./kg.	0.1 mg./kg. body weight	4.0 mg.
Hypothyroid Cardiac	0.5-1.0 mg.	1.0 mg.	4.0 mg.	4.0 mg.

Choloxin® (sodium dextrothyroxine)

Description

CHOLOXIN (sodium dextrothyroxine) is the sodium salt of the dextrorotatory isomer of thyroxine. It is chemically described as D-3,5,3',5'-tetraiodothyronine sodium salt.

Actions

The predominant effect of CHOLOXIN (sodium dextrothyroxine) is the reduction of serum cholesterol levels in hyperlipidemic patients. Beta lipoprotein and triglyceride fractions may also be reduced from previously elevated levels.

Most of the available evidence indicates that CHOLOXIN stimulates the liver to increase catabolism and excretion of cholesterol and its degradation products via the biliary route into the feces. Cholesterol synthesis is not inhibited and abnormal metabolic end-products do not accumulate in the blood.

Indications

This is not an innocuous drug. Strict attention should be paid to the indications and contraindications.

CHOLOXIN (sodium dextrothyroxine) is an antilipidemic agent used as an adjunct to diet and other measures for the reduction of elevated serum cholesterol (low density lipoproteins) in euthyroid patients with no known evidence of organic heart disease.

The drug is also indicated in the treatment of hypothyroidism in patients with cardiac disease who cannot tolerate other types of thyroid medication.

Before prescribing, note the following: Results from a randomized clinical study have indicated a possible adverse effect when CHOLOXIN is administered to a patient receiving a digitalis preparation. There may be an additive effect. This additive effect may possibly stimulate the myocardium excessively in patients with significant myocardial impairment. CHOLOXIN dosage should not exceed 4 mg per day when the patient is receiving a digitalis preparation concomitantly. Careful monitoring of the total effect of both drugs is important.

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Contraindications

The administration of CHOLOXIN (sodium dextrothyroxine) to euthyroid patients with one or more of the following conditions is contraindicated:

1. Known organic heart disease, including angina pectoris; history of myocardial infarction; cardiac arrhythmia or tachycardia, either active or in patients with demonstrated propensity for arrhythmias; rheumatic heart disease; history of congestive heart failure; and decompensated or borderline compensated cardiac status.
2. Hypertensive states (other than mild, labile systolic hypertension).

3. Advanced liver or kidney disease.
4. Pregnancy.
5. Nursing mothers.
6. History of iodism.

Warnings

CHOLOXIN (sodium dextrothyroxine) may potentiate the effects of anticoagulants on prothrombin time. Reductions of anticoagulant dosage by as much as 30% have been required in some patients. Consequently, the dosage of anticoagulants should be reduced by one-third upon initiation of CHOLOXIN therapy and the dosage subsequently readjusted on the basis of prothrombin time. The prothrombin time of patients receiving anticoagulant therapy concomitantly with CHOLOXIN therapy should be observed as frequently as necessary, but at least weekly, during the first few weeks of treatment.

In the surgical patient, it is wise to consider withdrawal of the drug two weeks prior to surgery if the use of anticoagulants during surgery is contemplated.

When CHOLOXIN is used as thyroid replacement therapy in hypothyroid patients with concomitant coronary artery disease (especially those with a history of angina pectoris or myocardial infarction) or other cardiac disease, treatment should be initiated with care. Special consideration of the dosage schedule of CHOLOXIN is required. This drug may increase the oxygen requirements of the myocardium, especially at high dosage levels. Treated subjects with coronary artery disease must be seen at frequent intervals. If aggravation of angina or increased myocardial ischemia, cardiac failure, or clinically significant arrhythmia develops during the treatment of hypothyroid patients, the dosage should be reduced or the drug discontinued.

Special consideration must be given to the dosage of other thyroid medications used concomitantly with CHOLOXIN. As with all thyroactive drugs, hypothyroid patients are more sensitive to a given dose of CHOLOXIN than euthyroid patients.

Epinephrine injection in patients with coronary artery disease may precipitate an episode of coronary insufficiency. This condition may be enhanced in patients receiving thyroid analogues. These phenomena should be kept in mind when catecholamine injections are required in sodium dextrothyroxine-treated patients with coronary artery disease.

Since the possibility of precipitating cardiac arrhythmias during surgery may be greater in patients treated with thyroid hormones, it may be wise to discontinue CHOLOXIN in euthyroid patients at least two weeks prior to an elective operation. During emergency surgery in euthyroid patients, and in surgery in hypothyroid patients in whom it may be advisable to withdraw therapy, the patients should be carefully observed.

There are reports that sodium dextrothyroxine in diabetic patients is capable of increasing blood sugar levels with a resultant increase in requirements of insulin or oral hypoglycemic agents. Special attention should be paid to parameters necessary for good control of the diabetic state in dextrothyroxine-treated subjects and to dosage requirements of insulin or other

antidiabetic drugs. If sodium dextrothyroxine is later withdrawn from patients who had required an increase of insulin (or oral hypoglycemic agents) dosage during its administration, the dosage of antidiabetic drugs should be reduced and adjusted to maintain good control of the diabetic state.

When either or both impaired liver or kidney function are present, the advantages of CHOLOXIN therapy must be weighed against the possibility of deleterious results.

Usage in Women of Childbearing Age

Women of childbearing age with familial hypercholesterolemia or hyperlipemia should not be deprived of the use of this drug; it can be given to those patients exercising strict birth control procedures. Since pregnancy may occur despite the use of birth control procedures, administration of CHOLOXIN (sodium dextrothyroxine) to women of this age group should be undertaken only after weighing the possible risk to the fetus against the possible benefits to the mother. Teratogenic studies in two animal species have resulted in no abnormalities in the offspring.

Precautions

It is expected that patients on dextrothyroxine therapy will show greatly increased serum protein-bound-iodine levels. These increased serum PBI values are evidence of absorption and transport of the drug, and should NOT be interpreted as evidence of hypermetabolism; similarly, they may not be used for titrating the effective dose of CHOLOXIN (sodium dextrothyroxine). PBI values in the range of 10 to 25 mcg% in treated patients are common.

If signs or symptoms of iodism develop during CHOLOXIN therapy, the drug should be discontinued.

A few children with familial hypercholesterolemia have been treated with CHOLOXIN for periods of one year or longer with no adverse effects on growth. However, it is recommended that the drug be continued in patients in this age group only if a significant serum cholesterol-lowering effect is observed.

Adverse Reactions

The side effects attributed to dextrothyroxine therapy are, for the most part, due to increased metabolism, and may be minimized by following the recommended dosage schedule. Adverse effects are least commonly seen in euthyroid patients with no signs or symptoms of organic heart disease; the incidence of adverse effects is increased in hypothyroid patients, and is highest in those patients with organic heart disease superimposed on the hypothyroid state.

In the absence of known organic heart disease, some cardiac changes may be precipitated during sodium dextrothyroxine therapy. In addition to angina pectoris, arrhythmia consisting of extrasystoles, ectopic beats, or supraventricular tachycardia, ECG evidence of ischemic myocardial changes and increase in heart size have been observed. Myocardial infarctions, both fatal and non-fatal, have occurred, but these are not unexpected in untreated patients in the age groups studied. It is not known whether any of these infarcts were drug related.

Changes in clinical status that may be related to the metabolic action of the drug include the development of insomnia, nervousness, palpitations,

tremors, loss of weight, lid lag, sweating, flushing, hyperthermia, hair loss, diuresis, and menstrual irregularities. Gastrointestinal complaints during therapy have included dyspepsia, nausea and vomiting, constipation, diarrhea, and decrease in appetite.

Other side effects reported to be associated with CHOLOXIN (sodium dextrothyroxine) therapy include the development of headache, changes in libido (increase or decrease), hoarseness, tinnitus, dizziness, peripheral edema, malaise, tiredness, visual disturbances, psychic changes, paresthesia, muscle pain, and various bizarre subjective complaints. Skin rashes, including a few which appeared to be due to iodism, and itching have been attributed to dextrothyroxine by some investigators. Gallstones have been discovered in occasional dextrothyroxine-treated patients and cholestatic jaundice has occurred in one patient, although its relationship to CHOLOXIN therapy was not established.

In several instances, the previously existing conditions of the patient appeared to continue or progress during the administration of CHOLOXIN; a worsening of peripheral vascular disease, sensorium, exophthalmos, and retinopathy have been reported.

CHOLOXIN potentiates the effects of anticoagulants, such as warfarin or Dicumarol, on prothrombin time, thus indicating a decrease in the dosage requirements of the anticoagulants. On the other hand, dosage requirements of antidiabetic drugs have been reported to be increased during dextrothyroxine therapy (see WARNINGS section).

Dosage and Administration

For adult euthyroid hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN (sodium dextrothyroxine) is 4 to 8 mg per day. The initial daily dose should be 1 to 2 mg to be increased in 1 to 2 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, if that dosage level is indicated to effect the desired lowering of serum cholesterol.

When used as partial or complete substitution therapy for levothyroxine in hypothyroid patients with cardiac disease who cannot tolerate other types of thyroid medication, the initial daily dose should be 1 mg to be increased in 1 mg increments at intervals of not less than one month to a maximum level of 4 to 8 mg daily, preferably the lower dosage. The maximum in patients receiving digitalis therapy is 4 mg.

For pediatric hypercholesterolemic patients, the recommended maintenance dose of CHOLOXIN is approximately 0.1 mg per kilogram. The initial daily dose should be approximately 0.05 mg per kilogram to be increased in up to 0.05 mg per kilogram increments at monthly intervals. The recommended maximal dose is 4 mg daily, if that dosage is indicated to effect the desired lowering of serum cholesterol.

If new signs or symptoms of cardiac disease develop during the treatment period, the drug should be withdrawn.

How Supplied

CHOLOXIN (sodium dextrothyroxine) is supplied in prescription packages of scored 1, 2, 4, and 6 mg tablets.

AN IMPORTANT NOTE:

It has not been established whether the drug-induced lowering of serum cholesterol or lipid levels has a detrimental, beneficial, or no effect on the morbidity or mortality due to atherosclerosis or coronary heart disease. Several years will be required before current investigations will yield an answer to this question.

Trustees Continue Search For Alternative UR Plan

The association's Board of Trustees decided on October 26th to authorize further negotiations with the Assistant Secretary of the Department of Health, Education and Welfare in an effort to gain approval of an OSMA-developed alternative to onerous hospital utilization review regulations for Medicare and Medicaid patients.

OSMA has been preimminent nationwide in its objections to cost-control concepts being advocated by the federal government. Federal officials are desperately trying to curb burdgeoning expenses of the \$24 billion-a-year health care plans.

At the 1975 annual meeting of the association's House of Delegates last April, a resolution was adopted which called for non-compliance with new federal utilization review regulations being imposed at that time.

These regulations, later to be the victim of a partially-successful AMA lawsuit, called for the certification of the medical necessity of each Medicare and Medicaid admission within 24 hours after the patient's entry into the hospital. This feature, in addition to a case-by-case review of all "long-stay" admissions, was seen by most Oklahoma physicians as being professionally disruptive, administratively inefficient, economically mis-directed as a cost-saving device, and unworkable in the many small rural hospitals of the state. Moreover, the 24-hour certification rule, and the resultant loss of Medicare-Medicaid benefits, could have deprived many patients of necessary medical services.

The House of Delegates authorized a voluntary assessment of the association membership to raise funds necessary to carry out a policy of non-participation, and nearly \$60,000 was collected. However, the AMA asked that the Oklahoma campaign be tabled until its lawsuit against DHEW was resolved, and at this point the OSMA Council on Public Policy and Officers of the OSMA met with the state's Congressional Delegation and federal officials

in Washington for the purpose of finding other means to settle the dispute.

At the meeting, the Assistant Secretary of DHEW, Theodore Cooper, MD, invited the OSMA to develop an alternative "superior plan" for possible application to Oklahoma in lieu of the federal regulations.

Association staff and the Council on Public Policy developed such an alternative by late June, and in July negotiations began to put the OSMA plan in place as a "demonstration project" which, if successful, could alter federal policy.

Meanwhile, as a result of the AMA lawsuit, DHEW Secretary Matthews withdrew the controversial regulations and said new cost-control rules would be drafted for implementation in the Fall.

OSMA "COST-EFFECTIVENESS PROGRAM"

The association concept differs from the prevailing federal attitude in that primary emphasis would be placed on retrospective audit of overall hospital medical staff performance rather than by concentrating on the harrassment of individual physicians through the federal concept of case-by-case review.

Under the OSMA plan, stringent review rules would only be focused on those hospital medical staffs and individual doctors who are determined by retrospective audit to be significantly deviant from acceptable professional standards as established by peer norms. Conversely, medical staffs with acceptable performance records of admission rates and lengths-of-stay would be "waivered" from most concurrent case-by-case review requirements as envisioned by federal officials. It is believed by those who understand the OSMA concept that its technique of selective "focused review," based on deviations identified by retrospective audit, will attain the same cost control objective desired by the government with greater professional acceptance and at considerably less expense.

The OSMA plan, if approved as a national demonstration project, would be operated by a division of the Oklahoma Foundation for Peer Review, an organization created by the OSMA to study the implementation of the federal "Professional Standards Review Organization" law. Another division of the foundation has already received a one-year \$114,000 federal contract to plan for PSRO implementation and, conceivably, the utilization review concept of

the OSMA-designed demonstration project could be adapted later on as the PSRO prototype for the state. Moreover, as mentioned above, a successful demonstration of the OSMA concept could possibly alter national PSRO policy.

APPROVAL BESET BY DELAYS

Although the association plan has been supported from the outset by Assistant Secretary Cooper, by the Director of the Bureau of Health Insurance (Medicare), and by the top federal Medicaid official, final Washington action has been delayed by legal entanglements, by a confused federal bureaucracy, and by the out-of-court settlement of the AMA lawsuit which temporarily called back current utilization review regulations for a massive re-write.

Washington officials have been in constant telephone contact with OSMA staff and, on one occasion, eight federal representatives spent two days in the OSMA offices discussing the association's proposal.

At present, it is expected that legal barriers to the approval of the demonstration project will be resolved in early November when

DHEW Secretary David Matthews approves an amendment to Medicare regulations drafted by Assistant Secretary Cooper and his staff. This amendment will then pave the way for final approval of the plan and an expected implementation date of January 1st.

The association's Board of Trustees has reserved the final authority to give the go-ahead sign after all elements of the negotiations are known and after comparisons are made to the new utilization review requirements now being drafted in Washington. There is speculation that new federal regulations may require preadmission certification of all elective surgery — a feature which could be avoided under the OSMA plan — and it is rather certain at this point that new regs will at best be considerably more stringent and professionally aggravating than the OSMA proposal.

OSMA's Board of Trustees may request a special House of Delegates meeting in December if warranted by the circumstances and if there is any question at that time that Board actions may have violated or compromised the April resolution of the Delegates regarding non-compliance with the now withdrawn federal regulations. □

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Malpractice Insurance Problems Studied

While malpractice insurance has become a significant problem to physicians in many states, Oklahoma doctors fare better than most, and so do their patients. So says a recent report by David K. McCurdy, assistant Oklahoma attorney general.

According to the report, Oklahoma remains in a relatively favorable position with respect to insurance rates and availability. "This results," it says, "in more reasonable and efficient medical care for the patient."

In his report to the Legislative Council's insurance committee, McCurdy says the malpractice insurance program offered by the Oklahoma State Medical Association "appears to have some of the lowest premium rates in the United States." Virtually every practicing physician in Oklahoma, it says, carries malpractice insurance through the OSMA program.

While increased exposure to the public, greater use of potent drugs, a change in medical technology, greater interest and a more litigation-minded public have all contributed to the rise in malpractice suits, says the report, several other factors have worked in Oklahoma's favor. First of all, Oklahoma is not urbanized and therefore, the state is temporarily insulated from many of the urban ills. Secondly, Oklahoma physicians appear to have a strong and effective state medical society which provides many benefits, including a group insurance program.

Due to the working relationship between the physician, the OSMA, and the insurer, it says, "Oklahoma is currently not faced with a problem of excessive rates or unavailability."

The assistant attorney general goes on to warn, however, that Oklahoma's enviable position may not be as permanent as the physician and his patients might like. In light of an opposite national trend, he says, "Oklahoma's position is indeed precarious." In order to forestall intensification and expansion of the problem, he predicts, preventive legislation will be necessary.

To date, the OSMA has endorsed five bills due to be reconsidered in the next session of the Oklahoma legislature. A list of OSMA endorsed bills and a brief description of their intent is shown below.

S.B. 450 . . . This bill would establish a statute of limitations for cases involving alleged malpractice. It would require malpractice suits to be filed within one year from the date of the injury, except in special cases involving discovery. In those cases, a maximum period of four years would be allowed.

S.B. 428 . . . This bill is designed to discourage the filing of non-meritorious lawsuits. It would allow the physician to file a "counterclaim." If the physician was found **NOT** negligent, the alleged injured party would have lost his suit to the physician.

S.B. 429 . . . This bill would provide that no guaranty or warranty of medical care would be valid unless stated in writing.

S.B. 451 . . . This bill would make information available to the jury concerning collateral sources of recovery available to the plaintiff.

S.B. 452 . . . This bill would serve to clarify the application of the *res ipsa loquitur* doctrine.

Further efforts to attack the problems involved with malpractice insurance are being made by the Professional Liability Study Commission appointed by Arnold G. Nelson, MD, OSMA President.

The commission recommended the OSMA study three proposals as a means of reducing the frequency of malpractice claims in Oklahoma. The proposals recommended by the commission at its September 7th meeting are:

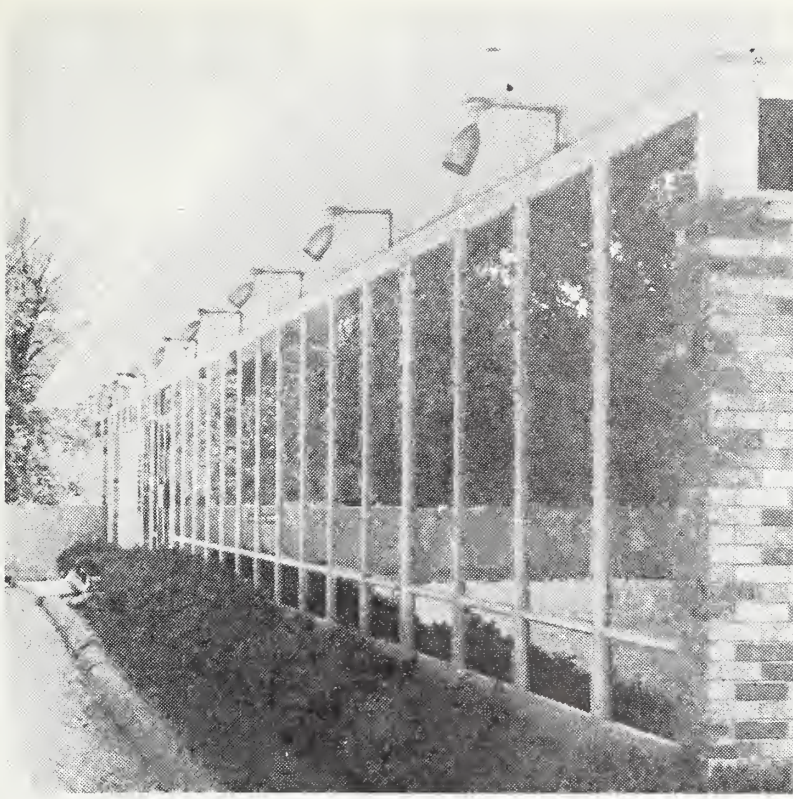
1. The establishment of a required course in professional liability for junior and senior students at the University of Oklahoma College of Medicine.

2. The establishment of a "Legal Indoctrination Course" for all state physicians. The course would be offered about two times a year, and efforts would be made to reduce the insurance premiums for participating physicians by about ten per cent.

3. That Continuing Medical Education be considered as a requirement for either OSMA membership or as a re-licensure requirement.

Executive Director Don Blair indicates the OSMA and its committees will continue to look into ways of solving the malpractice insurance problem.

Editor's Note: The full report by the Assistant Attorney General will be featured in a future issue of The Journal. □



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Program Completed for AMA Tulsa Regional Meeting

Tulsa will be the site of the AMA Regional Meeting on January 17th-18th, 1976. These Category 1 CME Courses will be held at the Tulsa Hilton Hotel. Co-sponsoring organizations along with the AMA include the University of Oklahoma Tulsa Medical College, the Tulsa Medical Education Foundation, the Tulsa County Medical Society and the Oklahoma State Medical Association.

Medical students and house staff physicians will be able to attend the courses free of charge.

The course schedule is as follows:

Saturday, January 17th, 1976

1. THE CHILD IN THE EMERGENCY ROOM — 8:00 a.m.-3:00 p.m. — Major case problems will be presented including management of multiple injuries, coma, seizures, poisoning, cardiorespiratory collapse, bites and stings and anaphylaxis. Faculty: Daniel C. Plunket, MD, Tulsa, Course Director; Delmer J. Pascoe, MD, San Francisco, California; Robert W. Block, MD, Tulsa; Charles L. Cooper, MD, Tulsa; Harold E. Goldman, MD, Tulsa; and Ralph W. Richter, MD, Tulsa.

2. FINANCIAL MANAGEMENT (AMA Course) — 8:00 a.m.-3:00 p.m.

3. BASIC LIFE SUPPORT COURSE IN CARDIOPULMONARY RESUSCITATION (Oklahoma Heart Association Course) — 7:30 a.m.-Noon.

4A. RECENT ADVANCES IN CARDIAC MANAGEMENT — 1:00-3:00 p.m. — Current management of the acutely ill patient with coronary artery disease, primarily acute myocardial infarction, will be stressed. In addition, one presentation will be devoted to the ways in which emergency medical care can be extended to the patient in the pre-hospital phase of acute myocardial infarction and to a system by which the smaller community hospital can provide monitoring and update its care of the patient with myocardial infarction. Faculty: Loyal L. Conrad, MD, Tulsa, Course Director; Gerald L. Honick, MD, Oklahoma City; Paul C. Houk, MD, Oklahoma City; John M. Kalbfleisch, MD,

Tulsa; Robert E. Lynch, MD, Tulsa; Jose R. Medina, MD, Tulsa; R. Wayne Neal, MD, Tulsa; Billy P. Loughridge, MD, Tulsa; Charles W. Robinson, Jr., MD, Oklahoma City; Richard C. Slagle, MD, Tulsa; and Robert P. Zoller, MD, Tulsa.

Sunday, January 18th, 1976

4A. continued — RECENT ADVANCES IN CARDIAC MANAGEMENT — 8:00 a.m.-3:00 p.m.

5. DERMATOLOGY FOR NON-DERMATOLOGISTS — 8:00 a.m.-3:00 p.m. — Cutaneous conditions commonly encountered in medical practice will be presented. Atopic dermatitis, cutaneous lesions in systemic disease, common cutaneous infections and benign and malignant cutaneous lesions will be reviewed. Current dermatologic therapy as well as review of diagnostic clues will be stressed. Faculty: Dwane B. Minor, MD, Tulsa, Course Director; Mark Allen Everett, MD, Oklahoma City; and Larry Millikan, MD, Columbia, Missouri.

6. MANAGEMENT OF THE CRITICALLY INJURED PATIENT — 8:00 a.m.-3:00 p.m. — With the increasing incidence of multiple-injured patients, an increasing burden of responsibility is being placed on the physician who works in the emergency department on a full or part-time basis. Head, neck and spinal injuries; thoracic, abdominal and genitourinary injuries will be reviewed. Management of shock, airway and cardiopulmonary complications will also be stressed. Faculty: C. T. Thompson, MD, FACS, Course Director; Clarence I. Britt, MD, Tulsa; J. C. Devine, MD, Tulsa; Gerald E. Gustafson, MD, Tulsa; Robert L. Imler, Jr., MD, Tulsa; John M. Kalbfleisch, MD, Tulsa; Edward O. Nonweiler, MD, Tulsa; John Phillips, MD, Tulsa.

7. ACID-BASE, FLUID AND ELECTROLYTE BALANCE — 8:00 a.m.-3:00 p.m. — The course objective is to provide a rationale for treatment of electrolyte, acid-base and water balance based on current understanding of normal physiology and pharmacology. Faculty: T. Richard Medlock, MD, Tulsa, Course Director; Jerome Kassirer, MD, Boston, Massachusetts; Solomon Papper, MD, Oklahoma City, and Robert W. Schrier, MD, Denver, Colorado. □

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Proposed Legislation Would Overhaul Workmen's Compensation System

A bill due to be introduced before the next session of the Oklahoma Legislature calls for an effective overhaul of Oklahoma's system of workmen's compensation. It was drafted by a special subcommittee of the Governor's Commission on Workmen's Compensation.

The proposed legislation is designed to aid both the physician and the State Industrial Court judge in compensation cases, allowing both to make judgments only in areas where they are trained. No longer would a physician be required to make subjective evaluations as to the per cent of disability. Likewise, impartial, third party medical expertise would be provided in cases where the medical opinions offered by the defendant and plaintiff differed concerning the cause of the disease or injury or differed greatly as to the percentage of impairment. Currently, such a difference must be negotiated by the industrial court judge, and he has the responsibility for making the final decision.

Under the planned system, medical evidence introduced by the employee and the employer would include an evaluation of the percentage of permanent impairment, but not the percentage of permanent disability. This would substantially lessen the burden on the physician, allowing him to confine his testimony to physical functioning, and it would relieve him of the responsibility of relating impairment to a specific job. For years, physicians have reasoned they are trained to make impairment evaluations but not the more subjective evaluations of disability. Under the bill, disability judgments would become the responsibility of the court.

In cases where the physicians for the employee and the employer could not agree on the cause of the disease or injury, or their evaluations of impairment differed by 20 per cent or more, the bill calls for the interested parties to choose a mutually agreeable third physician to make the final determination of impairment. If the two are not able to agree upon a third physician, one or more would be chosen by the judge from a medical panel established by the bill.

The medical panel is a concept currently being used by several other states. It would be made up of 60 physicians representing each of

the specialty fields recognized by the American Medical Association and the American Osteopathic Association. Forty of the physicians would come from a list provided by the Oklahoma State Medical Association and 20 would come from a list provided by the Oklahoma Osteopathic Association. Participating physicians would serve two-year terms.

Any physician chosen from the panel to appear before the court would have full access to all medical records, and he would be able to make any additional tests he felt were necessary. His evaluation of impairment would be conclusive and binding on the court, and the physician would be immune from all liability resulting from his appearance as an expert medical witness.

At this point, it is not definite who will introduce the legislation, but the OSMA plans to support the measure in principle. Not only would it get the physician out of the speculative business of evaluating permanent disability, but it would also provide that a physician, not a judge, makes the final decision on physical impairment. □

Medical Assistants Schedule Third Session

AAMA, Inc., State of Oklahoma, Inc., and the University of Oklahoma presents the third of six sessions designed to develop a first-rate medical assistant.

The workshops are held in the Forum Building at OCCE on the University of Oklahoma campus. Each program starts at 9:00 a.m. and is completed by about 3:00 p.m. Continuing Education Units at the rate of .6 CEU per session will be earned by each participant.

Family oriented care in a physician's office may be given adequately by following a few simple rules. Among these are being prepared for emergencies, knowing more about drugs, their side effects, and creating a clean environment in which to treat and care for the patient. An assistant will work with ease when she is prepared to assist the physician in physical examination of the patient, laboratory procedures, and x-ray techniques.

The third session, scheduled for December 6th, 1975, covers the clinical aspects of patient care in the physician's office. Gloria Peck, RN, Instructor, Inservice Education at the New Mercy Health Center, will be the lecturer for this session. □

Drug Substitution Bill Due Reconsideration By Oklahoma Legislature

A controversial bill designed to permit drug substitution without the approval or knowledge of the physician will apparently be reconsidered by the Oklahoma Legislature. David Bickham, OSMA Associate Executive Director in charge of legislative matters, explains although physicians and pharmacists joined together to defeat the bill in May, it is eligible for reconsideration during the 1976 session.

The controversial bill would allow pharmacists to substitute chemical equivalents for the drug originally prescribed by the physician. It has received the backing of many consumer groups who view the bill as a means of lowering health care costs, even though, in three states where substitution statutes have been modified, there is no evidence of any saving to the consumer.

Representative Mark Hammons, the bill's sponsor, has indicated he will push hard for favorable action by the Senate Committee on Public and Mental Health. After a half-day

public hearing during the last session, the substitution bill was not reported out of committee.

In the last session, the OSMA's Legislative Committee attempted to work out a compromise with Representative Hammons, and at one time, even supported the substitution concept. However, the committee's safeguards were never added to the bill, and the OSMA withdrew its support.

Although the bill promises to save the patient money, in Canada, where substitution has been allowed for ten years, there has been no demonstrable savings to the patient-consumer. Additionally, national surveys have shown consumers do not want chemically-similar drugs substituted for those prescribed, even at a reduction in cost.

The real issue to physicians and pharmacists is the very idea of substitution. Tests have shown few drugs have a chemical and therapeutic equivalent. Also, surveys show consumers are more interested in a drug's effectiveness and quality, than they are in the price. In most cases, patients feel the physician — not the pharmacist — should decide which drug is used in their prescription medications. □

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Rural Health Week Slated For Bicentennial Year

The week of April 4th, 1976, has been designated National Rural Health Week, it was announced recently by Max H. Parrott, MD, President of the American Medical Association.

Tennessee Ernie Ford has consented to act as national spokesman for the week, Doctor Parrott said. In addition to TV and radio appearances of Ford, other events are planned which will explore in public forums the achievements and challenges of rural health care.

The purpose of the week is to focus the attention of the American public on the health needs of rural America, to motivate rural citizens to become more health conscious, and to further rural-urban cooperation in health care issues.

In addition to the AMA, the American Dental Association, American Hospital Association, American Veterinary Medical Association, US Departments of Agriculture and Health, Education, and Welfare, and the National Safety Council are co-sponsors.

Other cooperating agencies and organizations include: the American Farm Bureau Federation, the National Grange, the AMA Auxiliary and state and local groups, the American Agricultural Editors' Association, the National Association of Farm Broadcasters, the American Public Health Association, the American Nurses' Association, Inc., the American Bankers Association, Prairie Farmer Magazine, Cooperative Extension Service, Farm Foundation, National Extension Homemakers Council, and the National Rural Electric Cooperative Association.

Each agency will contribute its own expertise, attacking specific segments of health care.

The week will be action-oriented and will center around some general topics: physician recruitments, emergency medical services, health education, development of health care facilities, and community organization for development of rural health care delivery systems.

National Rural Health Week is intended to be an event of the Nation's Bicentennial Celebration and will coincide with the 29th National Conference on Rural Health to be held in Phoenix, Arizona, April 7th-9th, 1976. □

OSMA Fills Communications Post

Don Blair, OSMA Executive Director, announced recently the appointment of Richard L. Hess to the new position of Director of Communications. Hess took over the OSMA post in late October.

The new position is designed to help develop a closer relationship between the medical association and the public. Hess will be concerned with both external and internal communications. He will write and edit the OSMA newsletter, contribute to *The Journal* and be in charge of media affairs.

Hess, who holds a BA degree in political science and a MA degree in journalism from the University of Oklahoma, comes to the OSMA by way of the Interstate Oil Compact Commission. He served as the IOCC's communications director during the past two years. His duties there were similar to those he has assumed at the OSMA.

When asked about the new position, Hess said his primary goal would be to keep both the association's members and the public aware of what is happening in health care. He said both the OSMA and the medical profession have historically done an excellent job, but the need to tell their story still exists. He said he hopes to open better lines of communications and let the association's performance stand for itself.

According to the new communications director, "Good public relations in any field requires two basic ingredients. First, the profession must do a credible job, and second, it must communicate with its public."

Hess said with the profession's record of service, he can concentrate his efforts on communications. □

Oklahomans Set For AMA Meeting

A record 310 persons have signed up for the OSMA-sponsored trip to the American Medical Association's Clinical Convention in Honolulu. A chartered 747 luxury jet will leave Oklahoma City on November 28th and return on December 7th, carrying probably the largest group of Oklahomans ever to attend an AMA meeting. While there, the Oklahoma delegation will stay at the Hawaiian Regent Hotel.

The first six full days in Hawaii, November 29th through December 4th, have been set aside for sessions of the AMA convention. The program is designed to meet the continuing

education needs of all physicians. Post-graduate topics at this year's meeting include hyperlipidemia, pulmonary function tests, newer antibiotics, basic and advanced EKG, dermatology for non-dermatologists, peripheral vascular diseases in children, pitfalls of E.R. x-rays, practical endocrinology, surgical lesions of the intestines, pediatric allergies, office gynecology, cardiopulmonary resuscitation, and many others.

But, the trip won't be all work. In addition to an interesting special program for the ladies, most class sessions have been scheduled between the hours of 7:15 a.m. and noon each day, leaving the afternoons free to enjoy the sights of Honolulu and Oahu.

As an added highlight, the OSMA tour includes a special, take your choice, trip to either the Mauna Kea Beach Hotel on Hawaii, or the Maui Surf Hotel on Maui Island. Participants will spend their last two days in Hawaii on their chosen tour before departing for Oklahoma City on December 7th.

The ten-day and nine-night meeting-tour is sure to provide an educational, memory-filled experience. ☐

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(Act of August 12, 1970, Section 3685, Title 39, United States Code)

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DEATHS

MAUDE M. MASTERSON, MD
1911-1975

A well-known Oklahoma City psychiatrist, Maude M. Masterson, MD, died October 24, 1975. Born in Walters, Oklahoma, Doctor Masterson was graduated from the University of Oklahoma College of Medicine in 1936 after having received her degree in pharmacy in 1933. Doctor Masterson had been an instructor in the Department of Medicine at the school of her graduation. She was a member of the American Psychiatric Association.

RURIC N. SMITH, MD
1887-1975

A retired Tulsa ophthalmologist, Ruric N. Smith, MD, 88, died October 23rd, 1975. A resident of Tulsa since 1920, Doctor Smith was formerly from Atlanta, Georgia, where he worked as a pharmacist. He graduated from the Jefferson Medical College of Philadelphia in 1915. Following five years practice in New York City, he established his offices in Tulsa.

He was a Fellow of the American College of Surgeons and the American Academy of Ophthalmology and Otolaryngology. Doctor Smith had received both a Life Membership and a Fifty-Year Pin from the OSMA.

WILLIAM G. PETERSON, MD
1904-1975

William G. Peterson, MD, an Ada otolaryngologist and ophthalmologist, died October 21st, 1975. He was a 1930 graduate of the University of Pittsburgh School of Medicine and had practiced his specialty for over 41 years.

Doctor Peterson was a Fellow of the International College of Surgeons, and was certified by the American Board of Otolaryngology. He was a member of the American Academy of Otolaryngology and Ophthalmology. ☐

OSMA To Sponsor Pension Program For Physicians

The association's Board of Trustees, on recommendation of the OSMA Council on Insurance, has authorized the council to develop a set of tax-deferred pension plans for association members.

Self-employed physicians will be able to enroll in a Keogh-type program whereby they may set aside up to \$7,500 annually without paying current income tax on that portion of their earnings. Incorporated doctors will be offered an option to enroll in either a profit-sharing or a corporate-type tax-sheltered program to be sponsored by the association. Physicians in this group may set aside an even larger percentage of their annual earnings.

Work on a physicians' retirement plan began as a result of redesigning the pension plan for association employees. The First National Bank and Trust Co. in Oklahoma City has been selected as the Trustee for all investment funds. At the present time, the investment

philosophy of the bank is being modified as a result of significant changes in management personnel. OSMA officials feel the investment funds of the pension programs will realize good earnings and sound management.

The insurance portion of the retirement packages will be underwritten by the Massachusetts Mutual Life Insurance Co. and will be administered by the Wilson Agency in Oklahoma City. It is one of the top agencies in Massachusetts Mutual's national organization, and new personnel are being employed for the sole purpose of handling the OSMA pension programs. IRS-approved trust agreements are in process now, and enrollment procedures should be commenced by January 1st.

A survey of association members conducted last summer revealed that 65% of the respondents wanted the OSMA to enter the pension field. Many physicians, in Oklahoma and elsewhere, have been disappointed with the handling of their tax-deferred retirement programs. Part of the problem can be contributed to general economic conditions, but a high per-

(Continued on Page 446)



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main purpose of drug information to the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it should depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a longer one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is

no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions, the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

ly the doctor can remove that fear of 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient about the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a pa-

tient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

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(Continued from Page 440)

centage of survey respondents also indicated dissatisfaction with their remote contact with pension managers.

The OSMA's Council on Insurance feels sufficient expertise is available in this state to successfully compete with national programs. Physicians who choose to participate in the OSMA pension programs will have the conven-

ience of localized management and OSMA involvement.

Any OSMA member who did not respond to last summer's survey may contact Don Blair of the OSMA office or Bob Bell, C.L.U., at the Wilson Agency, 1470 First National Building, Oklahoma City, Oklahoma, 73102. Initially, the Agency plans to contact those physicians who previously expressed an interest in an OSMA undertaking of this type, although all OSMA members will be contacted on a timely basis. □

Miscellaneous Advertisements

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One of the most rewarding places of service within the woman's medical auxiliary is in the area of American Medical Association — Education and Research Foundation or AMA-ERF to most of us. There is a quote on one of our brochures which states, "When society cannot afford to have what it cannot afford to be without, it is the occasion for intelligent giving." At no time in the history of the medical profession is this quote more true than in this time that we are living. At every turn medicine, doctors and health care are being undermined ethically and morally and the push is strong for a complete change in the type of medicine our doctors have practiced. Is there a course of action today's conscientious doctor's spouse can follow to help present a good healthy image of her husband's chosen profession and in turn do her part to insure a high quality of medical care?

It is evident to our state president, Loretta Renfrow, and myself as we travel from city to city throughout our state that women's medical auxiliaries exist because you care enough about the husband/wife medical partnership that we share to give your time and effort to promote medically oriented civic responsibility and good-will among your members. It has been good to be in such places as Garfield and Kay-Noble counties to share in your warmth and hospitality and feel your dedication. It is vital that we share in the work of our auxiliaries and let it be known to all that we care enough about the quality of medicine today to do our part to help keep its standards high and its doctors the very best.

The most accessible method we have as medical auxiliaries to make medicine better is through AMA-ERF. Today AMA-ERF is proud of gifts in excess of \$25,000,000 in unrestricted grants to our nation's medical schools and of guaranteeing over 53,000 loans worth more than \$61,000,000 for medical students, interns and residents since its inception in 1961. AMA-ERF also maintains funds for categorical research grants, scholarships and rural and community oriented health projects. We are



Shown attending the Garfield County Medical Auxiliary meeting, held September 17th, 1976, are (standing, l to r) Mrs. William Renfrow, Oklahoma City, state president; Mrs. Joe Stafford, Enid, state second vice-president; Mrs. Tony Puckett, Oklahoma City, state AMA-ERF chairman; and, seated Mrs. Don Karns, Enid, in whose home the meeting was held.

proud of the fact that two-thirds of the income to the foundation is received from physicians and their wives in the Woman's Auxiliary to the AMA.

Last year alone our state gave a total of over \$20,000.00 from its 1,286 auxiliary members for a \$16.50+ total per auxiliary member. Because of responses such as this throughout the United States, our national goal of "A Million and More" was attained. Our final tally was \$1,368,564.21! This represents an increase over the preceding year of over \$150,000.

"A Million and Six for '76" is our goal this year for AMA-ERF. A national goal can look pretty awesome at times but if each auxiliary member commits herself to our state goal of \$15.00 per person, we will have done our share to insure another banner year for a cause most worthy of our support.

As times grow more pressing for the medical profession, as the quality of medical care is threatened, let us all give intelligently to make medicine better for us all. □



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An investigation of Britain's National Health Service has been ordered by Prime Minister Harold Wilson. Wilson told the House of Commons he was creating a royal commission to consider the use and management of the service's financial and manpower resources. He acknowledged that the NHS, which has been strongly criticized in recent weeks, might need an overhaul. Junior hospital physicians have staged temporary work stoppages to protest pay and overtime conditions, and medical leaders have been at odds with Wilson who is trying to do away with private practice in the NHS system. Wilson has pledged backing for private practice, but he also has said he wants to rid the system of private-practice beds in NHS hospitals. Medical leaders fear this would hurt British health care by forcing physicians to either leave the country or devote all of their time to private patients.

Professional liability insurance will cost the Oklahoma physician more next year than ever before as underwriters of both the basic policy and the umbrella policy have announced sizable increases in their insurance rates. The growing national crisis appears to be the primary cause for the increases, although malpractice suits in Oklahoma are also rising. The Insurance Company of North America will charge physicians in Oklahoma 35 per cent more for the basic \$100,000 coverage. Additionally, a 15 per cent increase will go to establish a stabilization fund intended to stabilize the unknown factors in malpractice insurance, act as a contingency fund to protect INA against unknown or unsurfaced claims, and serve to induce INA to continue writing malpractice insurance. In effect, physicians will have to pay 50 per cent more for this insurance. At the same time, Continental National American, underwriter of the excess limits or umbrella plan, has announced a 100 per cent increase. CNA bases its on state losses. Therefore, CNA's increase is much larger. However, even with the rate hikes, Oklahoma physicians will still benefit from some of the lowest rates in the country. An indepth article

on malpractice insurance is featured in the November issue of *OSMA COMMENT*. If you did not receive your copy of the newsletter, or if you need extra copies, you may contact Richard Hess at the OSMA office.

A catastrophic-oriented national health insurance plan has been introduced into the Senate by Russell Long (D-La.) and Abraham Ribicoff (D-Conn.). The bill, much the same as last year's version, is co-sponsored by 11 other Senators including Senate Majority Leader Mike Mansfield (D-Mont.), Senate GOP Leader Hugh Scott of Pennsylvania, and Senator Herman Talmadge (D-Ga.), Chairman of the Finance Subcommittee on Health. The bill would provide all people with catastrophic coverage that would pay for everything above the cost of 60 days in a hospital or \$2,000. It would also provide for a uniform national benefit and eligibility structure with heavier federal contributions that would reshape the present Medicaid program to include the "working poor." Private health insurance carriers would have to meet government standards to qualify for participation in the catastrophic and other federal health programs. The insurance could be provided by either the government through a one per cent payroll tax or through employers' insurance plans in which case employers could receive a 50 per cent rebate. A separate Social Security trust fund would finance this provision. The cost of the program is estimated at \$7 billion a year.

A bill that would establish physicians' fee schedules under Medicare and Medicaid was opposed in a recent AMA letter to the House Ways and Means Committee's Subcommittee on Health. Under HR 6699, physicians participating in the program, to be set up by state governors, would have to accept the scheduled amount as full payment, and their payments would not be subject to the usual deductible and co-insurance. Physicians not participating would be paid on the basis of present reimbursement programs, subject to deductible and co-payment. The AMA said such a bill would "create an unprecedented system of price controls which is arbitrary and discriminatory." The AMA also said the bill is "grossly unfair and would cause immediate rollbacks in reimbursement for most physicians." □

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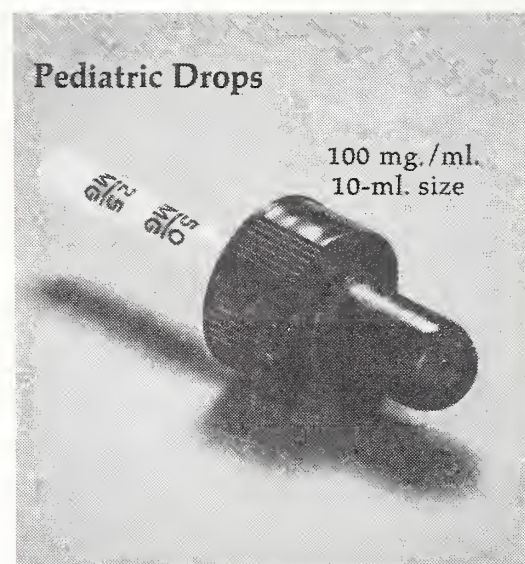
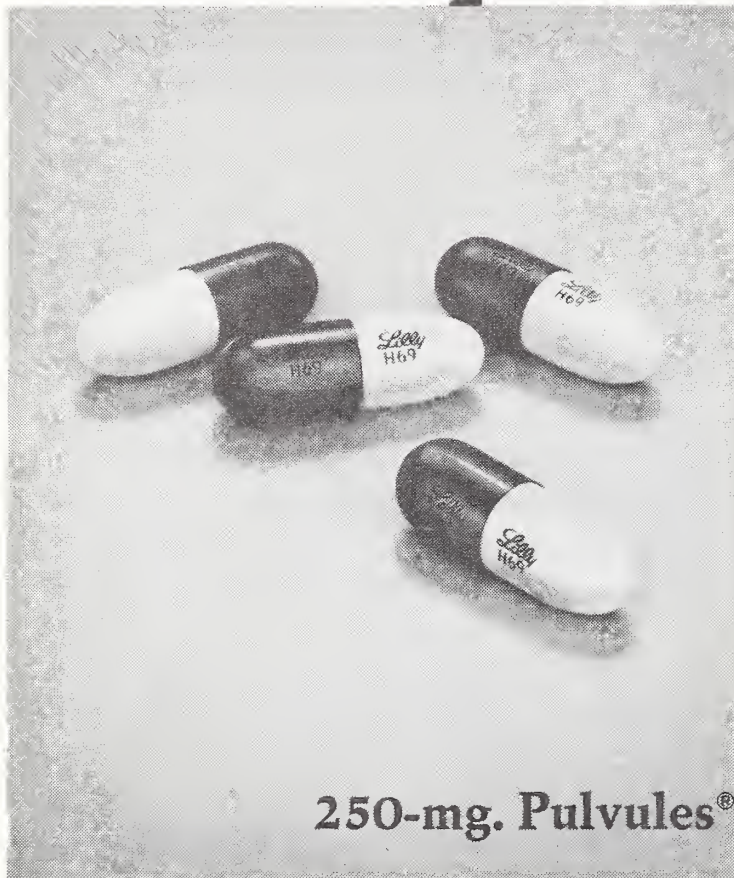
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Objections to Objective Examinations

If there is one experience which seems worse than the taking of an objective examination — usually of the multiple choice (M. Ch.) type —, it is composing one. The candidate has at least the thrill of a guessing game. From the start of this discussion one should realize that there is a semantic trick in the term “objective” examination. Only the scoring of the answers in this type of test is objective, ie it can be done without bias or effort by a machine or clerical help. The know-how, personality, diligence, and interests of the testers (the persons who design the test), their choice of questions in a given field with possible over-emphasis of a certain favored area, their selection of five alternative answers for each question, and the determination of the one and only correct or “best” answer are not at all objective or impartial. It must be pointed out that although every examiner thinks of himself as a competent composer of M. Ch. questions, one always starts out as an amateur in this field. It takes preliminary study of the literature on medical testing, supervision of the beginner by experienced testers, as well as a critical review of the prospective tests by one’s colleagues, before one can with confidence embark on the design of this type of examination.

The National Board of Medical Examiners (NBME), which has given M. Ch. tests for more than 20 years, has the advantage of having as participants experienced examiners, psychometric consultants, and a collection of test questions which have been tried out and evaluated previously. However, these assets in no way detract from the basic limitations of a M. Ch. test which will be discussed in this editorial. The term “objective” examination implies that other tests, particularly oral and essay tests, are subjective and should therefore be avoided. The topic of testing at all levels of medical education, including the threatening recertification examinations and the redesigned licensing and specialty board assessments is too

broad to cover in one editorial; but since we are at the crossroads in developing new evaluation procedures in medical education, the subject is of the greatest interest to everybody concerned.

To a certain extent and for various reasons we all have been brainwashed in favor of M. Ch. testing. What are its genuine assets in addition to the one previously mentioned, ie the standardization and ease of scoring? The M. Ch. test allows a much broader coverage of material than other forms of examinations. The most vociferous and influential proponent of objective testing, the NBME, uses an average of 160 M. Ch. questions in each major subject. This allows coverage of a wide range of subject matter. Bias against poor handwriting and unskillful choice of expressions is avoided.

What are the drawbacks of M. Ch. examinations? The results of this type of test depend to a great part on experience and skill of the candidates in handling such an examination, a fact that is really extraneous to the educational goal of this test, ie the evaluation of the candidate’s knowledge of factual material. Part of the “know-how” in taking it includes the technique of guessing. Since there are never more than five alternative items, only one of which must be correct, the candidate has a 20 percent chance of guessing right. This fact in favor of the candidate is of course increased if there are fewer than five choices or if one or more items are obviously incorrect. In common practice the test rewards simple memorization or even less than that, since only recognition of the correct answer rather than recall of a term or fact is required. One might conceive of this type of test as designed for students handicapped by a bizarre kind of aphasia and/or dyslexia in which they only have to identify the correct response by putting an X in the proper place without having to articulate the answer. If one then visualizes the thousands of candidates who since highschool days have been sub-

Editorial

(Continued From Page 449)

jected to a plethora of M. Ch. questions, it makes one want to take a new look at our system of testing and evaluation. It might be granted that an occasional M. Ch. test designed by an experienced examiner evaluates in addition to taxonomic knowledge also the ability to apply this knowledge to problem solving situations. But this can be done much better in an oral or essay type of assessment where the candidate can freely apply his factual knowledge to a reasoned argument and to critical evaluation of principles and abstract concepts. In such tests he can demonstrate his ability to organize the large amount of acquired facts for analysis and synthesis. Most certainly the M. Ch. test does not evaluate communication skills either in handling scientific arguments or in dealing with colleagues, patients, and their families.

The objective test also does not assess originality, creativity, or imagination. In contrast to a lawyer's question which has to be answered by a yes or no, there are many gray areas among the offered answers and exceptions to the "correct" item in the test question occur mainly to the knowledgeable and imaginative candidate. One is reminded of the old saw concerning a visit by the graduate to his old professor. On looking at the questions the professor is preparing for a test, the graduate reminds him that these were the same questions he gave them years ago. Whereupon the professor answers: "The questions are the same, but the answers have changed." Sinclair reports of a visit to a distinguished American anatomist at the time when the National Board Examinations were given in his school. He and his staff answered the questions out of interest and as it came out afterwards, they would have fared badly, even though the students whom they had taught did very well. It has been estimated that the Na-

tional Board Examination evaluates only about 50% of the testable qualities that are necessary to produce a satisfactory physician.

The M. Ch. test seems like a distorted allegory of real life where one often is faced with only a few and equally undesirable alternatives if one asks oneself the wrong questions. The outcome is decidedly more affected by the appropriate questions than the answers. In spite of these great shortcomings there are many schools that require the passing of Part I of the National Board Examination before promotion to the junior year and Part II before graduation. I have suggested to the Board that they preface their brochures by a statement of the limitations of this type of test and to add the recommendation that the participating institutions — in addition to the National Board Examination — use complimentary methods of evaluation.

While one may be fully aware of the built-in bias of oral and essay tests, they have the great advantage that they represent also a learning experience and can be utilized in "post mortem" discussions. In the essay-type test it is not so important that the test be graded, but that it be discussed, perhaps by one or two participants reading their own exposés to groups of students with the instructor acting as a moderator. The same advantage of being an instrument of education also holds true for practical and oral examinations.

The National Board itself is almost too modest or not fully aware of the maximum impact that it has in shaping educational policies throughout the country. One can hardly overestimate the influence of the National Board Examination on the design of the curriculum, on teaching methodology and testing procedures.

In summary: What we need is not more M. Ch. tests, but a choice of multiple types of tests.
Ernest Lachman, MD

Remember these dates —

May 6th, 7th, 8th, 9th, 1976

OKLAHOMA MEDICAL SUMMIT '76

Lincoln Plaza Forum

Oklahoma City, Oklahoma

This will be a combined meeting of the Oklahoma State Medical Association, the Oklahoma City Clinical Society and the Oklahoma Academy of Family Physicians.

PROFESSIONAL COURTESY

I recall an editorial written by Doctor Vernon Cushing, when he was President of the Oklahoma County Medical Society, some years ago, concerning professional courtesy when making telephone calls. That editorial impressed me very much, and I have never forgotten some of the principles that he stressed.



When calling a fellow physician by telephone, place the call yourself. It is just a little discourteous of a physician to have his secretary or nurse call another physician and hold him on the line, until you, the calling physician, are ready to talk. When placing a call in this manner, it would seem that the calling physician feels that his time is more valuable than that of the physician being called. I doubt seriously if any time is really saved by having the secretary do it for you.

There are exceptions though. In case you call a physician and find that he is not in his office and that it is apt to take several more calls, before you can find him, then it would save physician time to have some efficient office help place the call. Even then, be ready to talk when the physician is finally contacted.

On the other hand, don't you hate to call a doctor who is slow to come to the phone? We should all instruct our office help to get us on the phone immediately when a fellow physician is calling. Have you ever forgotten to come to the phone when another doctor calls you? I have! I think this is a most embarrassing situation. It is also most discourteous. So! Answer the call immediately to be sure this will never happen to you. It is not a bad idea to have your

secretary stay with you until the call is answered.

If a specialist wants to stop receiving referrals from some other physician, it can easily be accomplished by unprofessional telephone courtesy. Just try making the referring physician hold on the line an unnecessarily long time. You can believe the referring physician will find some one else to refer to!

The best policy is to place the call yourself, and when you receive a call, answer as soon as you can.

Incidentally, our association executives, who work so very hard in our behalf, are very busy, dedicated people. Instruct your receptionist to get you on the telephone immediately when they call. Extend them the same courtesy you would extend to a fellow physician. It's a good idea to have a list of names of people with whom you wish to speak immediately, at the receptionist's desk.

You know it is a funny thing, but we often are most careless with courtesy to the people who mean the most to us. Isn't that true?

Why can't we learn to be more courteous to the people we live and work with every day? It would make living or working together a great deal more satisfying.

Since we are talking about courtesy, how about the smile? Have you smiled at your fellow workers today? Have you said something nice to them that they deserve hearing? Let them all know in some way that you do appreciate them. Try it! Try it in the next few minutes and see how it works. It will make you feel better. It's almost like magic!

Arnald G. Nelson, D.D.

Reliability of Heart Disease Diagnoses

G. REZA NAJEM, MD, MPH, PhD
HARRIS D. RILEY, JR., MD
LEILA I. NAJEM, BS, MS

A study of the reliability of diagnoses of three forms of heart disease recorded on death certificates shows that nearly half of the diagnoses were unreliable according to the author's criteria.

Accuracy of death certificates is an important subject which should be of interest to all physicians, epidemiologists, statisticians, and health care planners. However, it has received surprisingly little attention.^{1,2} The medical literature contains many studies analyzing deaths attributed to heart diseases but few concerned with the reliability of these diagnoses.^{3,8}

Therefore, the present study was undertaken to evaluate the degree of reliability of the

cause of death statement on the death certificates of patients said to have died from one of three categories of heart disease: Ischemic heart disease (IHD), hypertensive heart disease (HHD), and chronic rheumatic heart disease (CRHD).

METHODS AND MATERIALS

Subjects for this study were residents of Oklahoma City who died in Oklahoma City and whose immediate cause of death was recorded as IHD, HHD, or CRHD. The study included a random sample of 100 (10.1%) deaths from IHD in 1970 and all deaths from HHD and CRHD (41 and 18, respectively) in 1969 and 1970, for a total of 159.

The 159 original death certificates were obtained from the Oklahoma State Department of Health. Three predesigned forms (one for all IHD, one for all HHD, and one for all CRHD) were used to obtain the clinical and some of the demographic information needed from hospitals, nursing and convalescent homes, physicians' offices, and the Medical Examiner's office. (These forms appear elsewhere.⁹)

Of the 159 cases in the sample, clinical information necessary for the study could not be obtained for nine cases (seven IHD, one HHD, and one CRHD), and these nine cases therefore were omitted from the study.

From the Departments of Pediatrics and of Community Health, Children's Memorial Hospital, University of Oklahoma Health Sciences Center and the Oklahoma Department of Institutions, Social and Rehabilitative Services, Oklahoma City, Oklahoma.

This paper was presented in the 101st Annual Meeting of the American Public Health Association and Related Organizations in San Francisco, California.

TABLE 1
SUMMARY OF CLASSIFICATION OF QUALITY OF SUPPORTING DIAGNOSTIC INFORMATION

Quality of Diagnosis	Ischemic Heart Disease	Hypertensive Heart Disease	Chronic Rheumatic Heart Disease
Definite	Autopsy findings or combination of at least two of the following: typical history of anginal pain, typical ECG, laboratory findings.	Autopsy findings or combination of history of hypertension and left ventricular hypertrophy (LVH).	Autopsy findings or combination of at least two of the following: history of rheumatic fever, typical clinical picture (heart murmur), definite ECG findings.
Possible	Suggestive history of anginal pain or suggestive ECG findings.	Combination of history of hypertension with suggestive LVH or suggestive Cardiac involvement.	History of rheumatic fever and suggestive clinical or ECG findings.
Doubtful	No detailed support of clinical diagnosis.	No detailed support of clinical diagnosis.	No detailed support of clinical diagnosis.
Wrong	Patient died of some other diseases and by mistake was certified or was coded under IHD.	Patient died of some other diseases and by mistake was certified or was coded under HHD.	Patient died of some other diseases and by mistake was certified or coded under CRHD.
Sudden Death	Includes DOA, SD, and VFD (Victim Found Dead).	Includes DOA, SD and VFD.	Includes DOA, SD, and VFD.

The available clinical information for each of the remaining 150 cases was measured against predetermined clinical criteria established by one of the authors (GRN). Table 1 briefly summarizes these criteria. (A detailed explanation of the criteria has appeared elsewhere.⁹) According to the author's judgment, each case was assigned to one of five categories (Definite, Possible, Doubtful, and Wrong diagnosis, and Sudden Death) relating to quality of diagnosis. (Table 1) (Details of this classification appear elsewhere.⁹)

When the author was in agreement with the diagnosis of cause of death on the death certificate (ie, according to the predetermined criteria it was considered a reliable diagnosis), the diagnosis was rated as Definite or Possible. When the author disagreed with the diagnosis on the death certificate (ie, according to the predetermined criteria it was considered an unreliable diagnosis), the death certificate diagnosis was rated as Doubtful or Wrong.

RESULTS

The results of the rating of quality of diagnosis are presented in Fig. 1. The highest proportion (47%) of IHD was "Sudden Death" and the smallest (4%) was the "Wrong" diagnosis. The highest proportion (41%) of CRHD was a "Definite" diagnosis, and there were no "Wrong" diagnoses among CRHD cases.

Of the 44 Sudden Deaths among IHD cases, 26 (61%) patients were Dead on Arrival (DOA),

8 (18%) were Victim Found Dead (VFD), and the remaining 10 (23%) were unexpected Sudden Death (SD). There were also four Sudden Deaths among the HHD cases and three among the CRHD cases — six of these were DOA and one was VFD.

When one excludes Sudden Deaths, over half (52%) of the cause of death statements on the remaining death certificates were in agree-

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Harris D. Riley, Jr., MD, was graduated from Vanderbilt University School of Medicine in 1948. He is now Professor of Pediatrics and Pediatrician-in-Chief of the Children's Memorial Hospital, University of Oklahoma Health Sciences Center in Oklahoma City. Certified by the American Board of Pediatrics, Doctor Riley is a member of the Society For Pediatric Research, the American Pediatrics Society and the Infectious Disease Society of America.

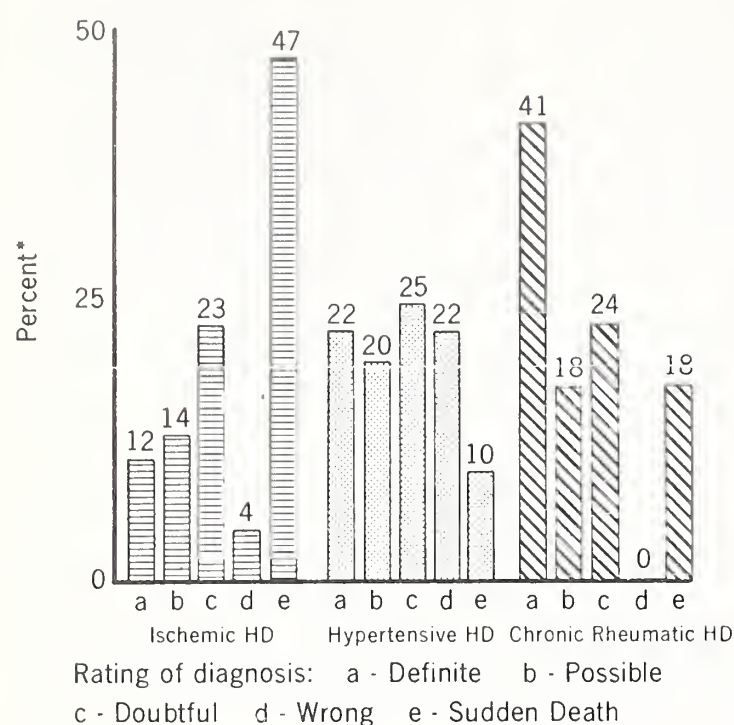


Fig 1. Percent distribution, by rating of reliability of each of the forms of heart disease (HD) on the death certificate.

ment with the author's criteria for diagnosis of the heart diseases. The percentage of reliable diagnoses (ie, Definite and Possible ratings) varied from 71% for CRHD to 49% for IHD and 47% for HHD.

Among cases diagnosed as acute myocardial infarction (excluding Sudden Death), 58% were in agreement with the author's criteria. The agreement was only 40% (excluding Sudden Death) for chronic IHD. The disagreement between death certificate diagnoses and the author's criteria was greater for hypertensive heart disease and renal disease than for HHD. The number of deaths from CRHD was too small to justify further analysis by specific cause of death.

Table 2 shows the rating of diagnostic reliability for the 150 deaths from IHD, HHD, and CRHD by sex. Among females, a considerable proportion of IHD and HHD was in the Doubtful and Wrong diagnosis category — a higher proportion than among males.

Table 3 indicates that the reliability of the diagnosis of IHD was greater for Caucasians than for Negroes, whereas the reverse was true for diagnosis of HHD.

The comparison of reliability of the heart disease diagnosis (excluding Sudden Death) on the certificate by sex and marital status is pre-

sented in Table 4. Reliability was considerably higher for married men than for married women. The unreliability (Doubtful and Wrong ratings) of the heart disease diagnoses in this study was considerably higher among unmarried women than unmarried men. Among women, the ratio of married to unmarried was about 1 to 2. Among men the ratio of married to unmarried was about 5 to 1 (this ratio is higher than the proportion of married to unmarried in the general population reported for Oklahoma City residents in the 1970 census).

The majority of the deaths from IHD (63%) and HHD (68%) and all deaths from CRHD were reported from hospitals. Table 5 shows that all diagnoses of IHD and 80% of HHD reported from nursing and convalescent homes were classified as either Doubtful or Wrong. As would be expected, the highest agreement was between the hospital diagnoses and the author's criteria for diagnoses of the heart diseases.

DISCUSSION

The accuracy of medical record and the completeness of cause of death statements depend upon 1) availability of pertinent diagnostic information; 2) diagnostic acumen on the part of

TABLE 2
THE RELIABILITY OF HEART DISEASE
DIAGNOSIS ON DEATH CERTIFICATES BY SEX

Reliability of Diagnosis	^a IHD		^b HHD		^c CRHD	
	Male	Female	Male	Female	Male	Female
Definite	8 (16)	3 (7)	8 (30)	1 (8)	3 (27)	4 (67)
Possible	6 (12)	7 (16)	5 (18)	3 (23)	2 (18)	1 (17)
Doubtful	7 (14)	14 (32)	6 (22)	4 (31)	4 (36)	0
Wrong	0	4 (9)	5 (18)	4 (31)	0	0
Sudden Death	28 (57)	16 (36)	3 (11)	1 (8)	2 (18)	1 (17)
Total	49 (100)	44 (100)	27 (100)	13 (100)	11 (100)	6 (100)

^a Ischemic Heart Disease

^b Hypertensive Heart Disease

^c Chronic Rheumatic Heart Disease

^d Numbers in parentheses are percents of total of each column

TABLE 3
THE RELIABILITY OF HEART DISEASE
DIAGNOSIS ON DEATH CERTIFICATES BY
RACE

Reliability of Diagnosis	a		b		c	
	IHD		HHD		CRHD	
	Caucasian	Negro	Caucasian	Negro	Caucasian	Negro
Definite	11 (13)	0	4 (16)	5 (33)	6 (40)	1 (50)
Possible	12 (14)	1 (10)	5 (20)	3 (20)	3 (20)	0
Doubtful	19 (23)	2 (20)	7 (28)	3 (20)	4 (27)	0
Wrong	3 (4)	1 (10)	6 (24)	3 (20)	0	0
Sudden Death	38 (46)	6 (60)	3 (12)	1 (7)	2 (13)	1 (50)
Total	83 (100)	10 (100)	25 (100)	15 (100)	15 (100)	2 (100)

^a Ischemic Heart Disease

^b Hypertensive Heart Disease

^c Chronic Rheumatic Heart Disease

^d Numbers in the parentheses are percents of total of each column

the physician; 3) the manner in which diagnoses were reported on the death certificate; and 4) coding accuracy of the registrar of vital statistics. This study took under consideration the effect of all these factors in estimating the degree of reliability of cause of death from heart disease recorded on the death certificates. Conclusions drawn from this study pertain only to the reliability of IHD, HHD, and CRHD diagnoses on death certificates in Oklahoma City based on one of the authors' (GRN) criteria.⁹

The results of this study indicated that 48% of diagnoses of cause of death on the death certificates were not in agreement with author (GRN) criteria.

Differences in the reliability of cause of death statements which were found in the present study may be attributed to some or all of the following factors:

1. Diagnoses showing the highest reliability (agreement with author's criteria) were from hospitals; the diagnoses rated least reliable were from nursing homes. This may well reflect both the intensity of diagnostic effort and the greater completeness of records which generally present in hospitals.

2. The unreliability of diagnosis of cause of death was higher for women (58%) than for men (41%). This may be explained partly by the differences in place of death. A large major-

TABLE 4
THE RELIABILITY OF CAUSE OF DEATH
FROM HEART DISEASE^(a) ON THE DEATH
CERTIFICATE, BY SEX AND MARITAL STATUS^(b)

	Diagnosis			Total	%
	Definite Possible	& Doubtful & Wrong			
MEN					
Married (%)	27 (61)	17 (39)	44 (100)		82
Unmarried (%)	5 (50)	5 (50)	10 (100)		18
WOMEN					
Married (%)	7 (41)	10 (59)	17 (100)		38
Unmarried (%)	12 (43)	16 (57)	28 (100)		62

^a Includes ischemic heart disease, hypertensive heart disease, and chronic rheumatic heart disease.

^b Excluding DOA and SD

ity (82%) of the male deaths but just over half (52%) of the female deaths occurred in the hospital. Conversely, more female than male deaths occurred in nursing homes, and diagnoses made in nursing homes were more unreliable than diagnoses made in hospitals.

3. The proportion of reliable diagnoses was slightly higher among married than unmarried patients. This also might be due to the fact that more married than unmarried patients died in the hospital in this study.

4. There were more unreliable diagnoses among chronic IHD deaths than among those from acute myocardial infarction. Perhaps, because of the severity of acute myocardial infarction, the physician was more concerned and performed more diagnostic procedures than he might in a case of chronic IHD. Diagnoses listing hypertensive heart and renal disease as the cause of death were less reliable than those listing hypertensive heart disease. Among all types of CRHD deaths, reliability was fairly high. These differences in reliability between the diseases may also be related to the place of death. About one-third of all deaths from IHD and HHD occurred outside hospitals, whereas all CRHD deaths occurred in hospitals.

5. In 4% of the cases, inaccuracies resulted from a mistake in the recording and coding of the underlying cause of death according to the ICD list. Such findings were also reported by other investigators.^{15,16}

The presence of 51%, 53%, 29%, and 18% un-

TABLE 5
THE RELIABILITY OF HEART DISEASE
DIAGNOSIS ON DEATH CERTIFICATES
BY PLACE OF DEATH

Reliability of Diagnosis	Ischemic Heart Disease			Hypertensive Heart Disease		
	Hospital	Nursing and convalescent homes	Not in hospital or other institution	Hospital	Nursing and convalescent homes	Not in hospital or other institution
Definite	11 (19) ^(a)	0	0	8 (30)	0	1 (12)
Possible	9 (15)	0	4 (17)	6 (22)	1 (20)	1 (12)
Doubtful	8 (14)	9 (90)	4 (17)	5 (18)	3 (60)	2 (25)
Wrong	3 (5)	1 (10)	0	5 (18)	1 (20)	3 (38)
Sudden Death	28 (47)	0	16 (67)	3 (11)	0	1 (12)
Total	59 (100)	10 (100)	24 (100)	27 (100)	5 (100)	8 (100)

^a Numbers in parentheses are percents of total of each column

reliable diagnoses of IHD, HHD, CRHD and SD (respectively) in this study shows the possible inaccuracy of the cause of death diagnoses on death certificates. In the light of the high proportions of unreliable diagnoses found in this study, one must raise serious doubts about the use of such types of current death certificate data in Oklahoma City for research purposes. The epidemiological study of deaths from heart disease based on such information must be re-examined to determine whether there is significant bias in the way the errors are associated with the factors under investigation. Material to be used for such studies must first be refined and adjusted with this uncertainty in mind.

SUMMARY

This study evaluated the degree of reliability of the diagnoses of cause of death found on the death certificates of Oklahoma City residents said to have died from IHD, HHD, and CRHD. A random sample of 10.1% of deaths from IHD in 1970 and all deaths from HHD and CRHD in 1969 and 1970 were studied. The medical records of these cases were reviewed and the reliability of the diagnoses was judged by predetermined clinical criteria.

Over half (52%) of all diagnoses were in agreement with the author's criteria for diag-

nosis of the respective heart disease. The percentage of agreement by forms of heart disease varied from 71% for CRHD to 49% for IHD and 47% for HHD. Various factors might explain the greater unreliability of the cause of death statements found among patients dying outside of the hospital (particularly in nursing homes), the unmarried, and women. Unreliable diagnoses were more frequent among chronic IHD cases than acute myocardial infarction cases, and more among hypertensive heart and renal disease than HHD cases. In 4% of the cases, inaccuracies resulted from mistakes in recording and coding of the cause of death.

Results of this study suggest that, in order for information on death certificates to be used for research purposes, it needs to be refined and adjusted for the proportion of unreliability of diagnosis. □

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Internal Medicine Review Course

1975-76

Every Thursday— 5:00 to 6:30 P.M.

EAST LECTURE HALL

Basic Science Education Building

University of Oklahoma, College of Medicine

Oklahoma City, Oklahoma

Coordinator: Dale Groom, MD

SECOND SEMESTER SCHEDULE

DATE — TITLE — SPEAKER

January 8th, 1976—ASCVD and Cardiomyopathies, Stephen D. Shappell, MD

January 15th, 1976—Pulmonary I—Recent Advances in Pulmonary Disease, C. Dowell Patterson, MD, David Levin, MD

January 22nd, 1976—Pulmonary II—Use and Interpretation of Pulmonary Function Tests, Larry Ayers, MD, Bernard E. Pennock, PhD

January 29th, 1976—Pulmonary III—Interpretation of Arterial Blood Gases—Respiratory Failure, Robert M. Roger, MD, Barry A. Gray, MD, PhD

February 5th, 1976—Diabetes, Hypoglycemia and Calcium, James Males, MD

February 5th, 1976—Deficits and Excess of Other Electrolytes, W. O. Smith, MD

February 19th, 1976—Renal II—Acid Base Disturbances and Therapy, Chris Kaufman, MD, Robert D. Lindeman, MD

February 26th, 1976—Renal III—Urinary Tract Infection, Stone Formation, Anthony Czerwinski, MD

March 4th, 1976—Renal IV—Acute and Chronic Renal Failure, Etiology and Management, J. A. Pederson, MD, Anil K. Mandal, MD

March 11th, 1976—Infectious Disease I, John Mohr, MD

March 18th, 1976—Infectious Disease II, Hanna Saa'dah, MD

March 25th, 1976—Gastroenterology I, Gastroenterology Section

April 1st, 1976—Gastroenterology II, Gastroenterology Section

April 8th, 1976—Current Concepts of Hematology, Walter H. Whitcomb, MD

April 15th, 1976—Congenital Heart Disease in the Adult, Lotfy L. Basta, MD

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Renovascular Hypertension

S. S. SANBAR, MD, PhD

An estimated 23 million people in the United States have hypertension. At least five per cent of all hypertensives have renovascular hypertension, the latter being the most common, potentially curable form of hypertension.

DEFINITION AND INCIDENCE

Renovascular hypertension comprises a group of disorders which intrinsically or extrinsically affect the blood supply of one or both kidneys, and secondarily induces renal ischemia of sufficient magnitude to produce hypertension.

Renovascular disease can exist and not induce sufficient renal ischemia to cause hypertension.

An estimated 23 million people in the United States have hypertension. At least five per cent of all hypertensives have renovascular hypertension,¹⁻³ the latter being the most common, potentially curable form of hypertension.¹

This manuscript depicts an overview of renovascular hypertension, with particular emphasis on special procedures used in selecting patients in whom surgery might offer a cure.

HISTORICAL LANDMARKS

Richard Bright (1827)⁴ noted an association

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between "hardening of the kidneys" and dropsy, a full, hard pulse and left ventricular hypertrophy. Traube (1856)⁵ surmised that the latter cardiovascular alterations may be secondary to hypertension. Mohamed (1874)⁶ demonstrated an association between renal disease and "high tension in the arterial system."

Goldblatt *et al* (1934-1937)^{7,8} produced experimentally sustained hypertension in the dog by constricting a renal artery with resultant renal ischemia.

Leadbetter and Burkland (1938)⁹ described relief of hypertension following nephrectomy in a 5-year-old patient who had renal artery obstruction.

CLASSIFICATION OF RENOVASCULAR HYPERTENSION

The following classification is a modification of that reported by Kaplan,¹⁰ who also notes the appropriate literature references.

A. Vascular wall lesions:

1. Atherosclerosis of main (extrarenal) renal arteries.

2. Fibroplasia of intima of arterial wall.

3. Fibromuscular dysplasia of media of arterial wall, comprising medial fibroplasia, hyperplasia or dissection, and perimedial fibroplasia.

4. Arteriolar nephrosclerosis, and "malignant" hypertension with medial necrosis of arterioles.

5. Arteritides, including polyarteritis nodosa, Takayasu's disease and rejection of renal transplant.

6. Miscellaneous, including renal arterial aneurysms, angiomas, arteriovenous fistulas, neurofibromatosis, and traumatic occlusion.

B. Intravascular lesions:

1. Emboli or thrombi, be they atheromatous, bacterial or fungal vegetations of cardiac or aortic origin, and tumor or leukemic thrombi with resultant renal ischemia or infarction.

2. Renal vein thrombosis, idiopathic or secondary to ascending thrombophlebitis.

3. Disseminated intravascular coagulopathy.

C. Extravascular lesions which impede or "steal" the renal blood flow:

1. Congenital fibrous band.

2. Ptosis of kidneys and secondary kinking of renal artery.

3. Compression with tumor, as occurs at times with a pheochromocytoma or metastatic tumors.

4. Stenosis of coeliac axis with "steal" of renal blood flow and secondary renal ischemia.

5. Subcapsular perirenal hematoma.

6. Ureteral obstruction.

It is apparent from the above that the physician must delineate the type of renovascular lesion producing the hypertension. Fortunately, the most common of the renovascular lesions are those which cause stenoses as a result of either an atherosclerotic, fibrous or fibromuscular arterial disease. The remainder of this paper will therefore concentrate on these most common pathologic entities. The latter pathologic processes are not limited to the renal arteries; other arteries may be involved concomitantly, and progression of the pathologic processes has been demonstrated in about one-third to one-half of patients who were followed for several years.^{11,13} Another comprehensive pathologic classification of renal arterial disease in renovascular hypertension has been provided by Harrison and McCormack.¹⁴

PATHOPHYSIOLOGY

The mechanism by which hypertension develops secondary to renal artery stenosis is complex and not fully understood.¹⁵ The following is a simplified explanation of the renin-angiotensin-aldosterone control system as it relates to renovascular hypertension.

Renal artery stenosis decreases *renal perfusion pressure*. In response to the latter, the *renal juxtaglomerular cells* secrete increased amounts of *renin*, a proteolytic enzyme. Renin

acts on *angiotensinogen* (renin substrate, a circulating protein synthesized by the liver) to form *angiotensin I*, a decapeptide that is physiologically inactive. A *converting enzyme*, present in greatest concentration in lung tissue, splits off two terminal amino acids from angiotensin I and converts it to the octapeptide *angiotensin II*, a most potent vasoconstrictor. In addition, angiotensin II directly stimulates secretion of *aldosterone* from the adrenal cortex. Aldosterone promotes sodium retention by the kidneys. Thus, hypertension results from both direct vaso-constriction as well as sodium, and secondarily water, retention.

The renin-angiotensin-aldosterone system is partly kept in check by *renin inhibitors* which control renin release, *angiotensinases* that degrade angiotensin, and *metabolic inactivation of aldosterone*.

CLINICAL CLUES

The clinical manifestations of renovascular hypertension are generally *not* distinctive; the symptoms reflect primarily the severity of hypertension. However, there are certain clinical clues which strongly enhance the likelihood of discovering renovascular hypertension.^{15,17} These include the following:

1) *Age at Onset of Hypertension*. Patients whose onset of hypertension begins below age 35 or above 50 years are more likely to have renovascular lesions.

2) *Sex*. Below age 35 years females are more commonly affected than males, with the pathologic lesion being fibrous or fibromuscular disease. On the other hand, males predominate above age 50 years with arteriosclerotic disease as the pathologic lesion producing renal artery stenosis.

3) *Race*. Whites outnumber blacks by a ratio of 9:1 in renovascular disease.

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4) *Family History.* About two-thirds of patients with renovascular hypertension give a *negative* family history of hypertension.

5) *Abdominal bruit.* This is perhaps the *most helpful clinical clue.* About half the patients with renovascular hypertension have an upper abdominal, and less commonly, flank bruit which is characteristically *high-pitched and continuous* in systole and diastole. A bruit is more likely to be heard in fibromuscular than in arteriosclerotic disease of the renal arteries.

6) *Peripheral vascular disease.* Patients above age 50 years with arteriosclerotic occlusive disease of the abdominal aorta or medium-sized arteries such as the femorals and the carotids are more likely to have involvement of the renal arteries as well.

These clinical clues are generally in keeping with the findings in 20 consecutive patients with renovascular hypertension, seen at our clinic between 1971 and 1973. (Table I)

In contrast with renovascular hypertensives, patients with *essential* hypertension have a mean age of 41 years, are more commonly black, have a high incidence of positive family history of hypertension, and about seven per cent only have upper abdominal bruits.

DIAGNOSTIC PROCEDURES

It is generally agreed that *young* individuals, below 35 years of age, with sustained

hypertension of moderate or severe degree deserve a thorough evaluation for a curable cause of hypertension. In patients *over 50 years of age*, on the other hand, there is no uniformity of opinion with respect to the completeness of laboratory evaluations.¹ Routine laboratory studies offer no help in diagnosing renovascular hypertension. Hence, one resorts to the following special procedures:

1) *Hypertensive IVP:* The intravenous pyelogram with rapid multiple-filming immediately after injection of contrast material has been of proven value for screening hypertensive patients for renal or renovascular lesions. The Renovascular Hypertension Cooperative Study¹⁸ indicates that among patients with renovascular hypertension with less than 50% stenosis, about 22% have abnormal hypertensive IVP. Of those patients with greater than 50% stenosis, about 78% have abnormal hypertensive IVP. However, false positives occur in about 11% of patients with essential hypertension.

The abnormalities in the hypertensive IVP that suggest the possible presence of renovascular hypertension include:

a) Unilateral delayed appearance of contrast material,

b) Delayed excretion and hyperconcentration of contrast material on the involved side,

c) Difference in renal size in excess of 1.5 cm in the absence of a duplicating collecting system,

TABLE 1
CLINICAL FINDINGS IN 20 PATIENTS WITH RENOVASCULAR HYPERTENSION*

Patient Number (Initials)	Age Yrs.	Sex	Race	Highest BP Recorded	Duration of Hypertension	Hypertension in Family	Abdominal Bruit	Non-renal Vascular Disease	Hypertensive IVP	Arteriographic Renovascular Stenosis
1 (L.S.)	26	F	C	170/110	6 years	Mother	absent	none	normal	Fibromuscular
2 (J.C.)	35	M	B	260/160	2 years	Mother	absent	none	normal	Fibromuscular
3 (B.M.)	41	F	C	180/100	1 year	Sister	present	none	abnormal	Fibromuscular
4 (H.A.)	47	F	B	150/110	1-1/2 yrs.	Mother	present	present	normal	Atherosclerosis
5 (R.B.)	51	F	C	160/120	6 months	Father	absent	none	normal	-do-
6 (R.N.)	52	M	C	232/110	5 years	none	present	present	abnormal	-do-
7 (A.D.)	53	M	B	170/120	1-1/2 yrs.	none	absent	none	normal	-do-
8 (M.F.)	56	F	C	200/140	5 years	none	present	present	normal	-do-
9 (R.D.)	59	F	C	170/105	1-1/2 yrs.	parents	present	present	abnormal	-do-
10 (M.S.)	59	F	C	170/100	6 years	mother	absent	none	abnormal	-do-
11 (R.H.)	61	F	C	220/120	3 years	none	absent	none	normal	-do-
12 (L.R.)	63	F	C	250/120	25 years	Father	present	present	abnormal	-do-
13 (E.K.)	65	F	C	242/120	21 years	Father	present	present	normal	-do-
14 (W.M.)	68	M	C	180/110	4 years	none	present	present	normal	-do-
15 (H.G.)	69	M	C	170/110	unknown	none	absent	present	normal	-do-
16 (C.E.)	69	M	C	220/130	unknown	none	present	none	abnormal	-do-
17 (F.L.)	73	F	C	260/110	24 years	none	present	present	abnormal	-do-
18 (L.F.)	73	F	C	220/130	5 years	none	present	none	abnormal	-do-
19 (G.W.)	78	M	C	160/100	unknown	none	absent	none	normal	-do-
20 (A.J.)	87	F	C	190/100	12 years	none	present	present	normal	-do-

*Patients seen at the High Blood Pressure, Hyperlipidemia and Cardiovascular Disease Clinic from 1971-1973.

d) Ureteral scalloping, secondary to dilated, tortuous ureteral collateral arteries, especially if associated with delayed appearance and hyperconcentration of contrast material.

e) Irregular contour of the kidney silhouette secondary to renal infarction and localized atrophy,

f) and finally, unilateral failure to concentrate contrast material.

Delayed appearance time of contrast material is the most frequent abnormality seen in the hypertensive IVP of patients with renovascular hypertension.^{15,18}

In 1962, Amplatz¹⁹ proposed the "pyelogram-urea washout" test to accentuate the difference in contrast material in the calyces during a hypertensive IVP.

In 1972, *vasodilated hypertensive IVP* was described by Wolf and Wilson²⁰ as an improved screening test for renal artery stenosis. This test employs ethacrynic acid, a potent renal vasodilator, and analyzes the alterations in renal sizes after vasodilatation.

2) *Isotope Renogram*: Introduced by Taplin *et al*²¹ and tested by Winter²² in 1956, the radioisotope renogram is a simple and safe screening technique for the detection of renal arterial stenotic lesions, be they unilateral, bilateral or branch arterial stenoses. It has a false negative rate of 14 per cent and a high false positive rate.¹⁵

The isotope *renogram* should not be confused with the *renal scan*, the latter being of limited, if any, usefulness in the search for renal artery stenosis.

3) *Renal Arteriography*: This invasive technique (Fig 1) is the definitive means of demonstrating the presence or absence of renal arterial lesions.^{23,24} Renal arteriography is best performed with selective catheterization of individual renal arteries. Catheters may be introduced via the femoral or brachial arteries or translumbar aorta. The femoral approach is the simplest one; the other approaches are used when there is severe occlusive disease of the abdominal aorta or the iliac arteries thereby precluding retrograde femoral catheterization. The indications for renal arteriography in a hypertensive patient are:

- a) the previously mentioned *clinical clues*
- b) abnormal hypertensive IVP or isotope renogram
- c) sudden acceleration of previously controlled hypertension

Renal arteriography is not performed in (a) patients with a known cause of hypertension, such as increased intracranial pressure or coarctation of the aorta, (b) patients who are suspect of having adrenal hormone secreting tumors (Cushing's disease, pheochromocytoma or primary aldosteronism) and (c) patients whose clinical status is so precarious that such surgery would be contraindicated.

4) *Differential Renal Function Studies*: Selective retrograde catheterization of ureters is very helpful in determining the functional significance of a renovascular lesion. When the renal artery stenosis is functionally significant, the urine volume is reduced by 25 per cent or more, while the concentrations of creatinine and exogenous substances such as inulin and PAH (para-aminohippurate) are increased by 25 per cent or more, in the involved (ipsilateral) kidney. The *Howard Test* employs split urine volume and creatinine concentration, while the *Stamey Test* employs urine volume and PAH concentration. The *Rapoport Test* and the *Birchall Test* are two other modifications of the Howard Test.¹⁰

Differential renal function studies are infrequently utilized nowadays because of the complexity of the procedure and the associated morbidity and mortality.

5) *Angiotensin Infusion Test*: Kaplan and Silah²⁵ were able to differentiate patients with renovascular hypertension from essential hypertensives by continuous intravenous infusion of angiotensin, the rationale being that renovascular hypertensives have high endogenous levels of angiotensin, and hence show a diminished pressor response to infused exogenous angiotensin. This test, however, has high false positives and false negatives, and is generally not used at present.

6) *Renin Determination*: Peripheral arterial and venous and selective renal vein renins have been found to be collectively useful in identifying renovascular hypertension and predicting curability. Three indicators have been defined recently by Vaughan *et al*²⁶ to predict success following surgical correction of renal artery stenosis:

- a) an abnormally high peripheral plasma renin activity in relation to sodium excretion, indicating increased renin secretion
- b) complete suppression of renin secretion from the contralateral kidney
- c) an abnormally increased renal vein renin content relative to arterial renin from the



FIGURE 1. (a) Top left, selective left renal arteriography demonstrating a severe stenosis shortly after the origin of the left main renal artery. (b) Top right, bilateral renal artery stenosis, very severe on the right, with smaller right kidney. (c) Bottom left, bilateral renal artery stenosis, greater on the right side. (d) Bottom right, complete occlusion of left renal artery, and severe narrowing of right renal artery, as well as intrarenal stenosis resulting in minimal renal blood flow.

ipsilateral kidney. If the venous - minus arterial-renin divided by arterial renin is greater than 0.48, the difference is considered significant.

Michelakis *et al*²⁷ have also noted that when the ratio of renal vein renin activity from the ipsilateral kidney to the contralateral kidney is 1.5 or greater, the test is considered positive, indicating significant renal artery stenosis.

Unfortunately, the determination of renal vein renin is of less value when both renal arteries are stenosed. Furthermore, the assay of renin is not readily available locally for most physicians, and the results of samples mailed out are not completely dependable.

Selective renal vein renins, determined accurately and dependably, represent the best current means available for predicting

whether or not arteriographically proven renovascular stenosis is causally related to the hypertension.

CHOICE OF THERAPY

A. *Surgery* is the treatment of choice for renal artery stenosis that is greater than 50 per cent and is producing significant functional impairment of the involved kidney. The magnitude of stenosis can be readily evaluated by renal arteriography. On the other hand, determination of functional significance of the stenosis is not so clear cut. The reason is apparent when one subdivides the patients under the following categories and subcategories.

A. *Atheromatous disease of the renal arteries.*

1) Unilateral stenosis is present in about one-third of the patients,

2) Bilateral stenosis is present in the remainder, sometimes with complete occlusion of one of the arteries and high-grade stenosis in the other.

B. *Fibrous and Fibromuscular disease of the renal arteries.*

1) Unilateral stenosis is present in approximately two-thirds of the patients,

2) Bilateral stenosis is present in the remaining third.

While the laboratory procedures available are very helpful in *unilateral* stenosis, their usefulness becomes increasingly limited when the disease is bilateral with significant stenoses and at times total occlusion of one of the renal arteries. These difficulties in proper selection of candidates who could benefit from surgery are reflected in the reported long-term results following surgical correction. Approximately half of the patients operated normalize their blood pressure. About 30 per cent are improved and about 20 per cent are unchanged with respect to their hypertension.

However, with proper selection of patients, using rigid criteria, Vaughan *et al*²⁶ have reported 100 per cent success rate. Foster *et al*²⁸ reported post-operatively in 502 patients with renal artery stenosis and hypertension, that 51% were cured, 15% improved and 34% were failures; their operative mortality was 5.9%.

Hypertension is not the only indication for surgery in renovascular disease. One should also consider preservation of renal function, particularly in patients with complete occlusion of one renal artery and a high-grade

stenosis in the opposite renal artery associated with azotemia or uremia. In the latter patient, surgery may involve nephrectomy on the side of total occlusion and an aorto-renal bypass on the stenotic side. Unfortunately, however, the revascularized kidney does not always resume good function. Sheil *et al*²⁹ reported three patients with renovascular hypertension and sudden deterioration of renal function, two patients requiring dialysis; "revascularization resulted in reversal of renal failure and restoration of good health."

B. *Medical therapy* for renovascular hypertension is indicated in the following circumstances:

1) Where the stenosis is unilateral or bilateral and is less than 50 per cent with no clear-cut evidence of functional renal impairment.

2) In bilateral disease with severe involvement of *intrarenal* branches, particularly in fibromuscular disease.

3) Patients with severe, generalized arteriosclerosis, who cannot withstand surgery.

FOLLOW-UP

Patients who are discovered to have renovascular hypertension should be followed regularly not only to control the hypertension but also to monitor progression of the disease. Gifford³⁰ recommends yearly hypertensive IVP and possibly renogram are indicated, and renal arteriography every two to three years.

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SUMMARY

1. Renovascular diseases are in some patients causally related to hypertension. The various renovascular lesions are classified under three headings: vascular wall, intravascular and extravascular lesions. Renovascular disease may also occur in normotensives.

The pathophysiology of the renin-angiotensin-aldosterone control system is presented as it relates to renovascular hypertension.

3. Clinical clues and diagnostic procedures, cur-

rently available, are presented, including clinical findings in 20 of our patients.

4. The choice between surgical versus medical therapy for renovascular hypertension appears to be somewhat less confusing, as better criteria for patient selection are delineated and adhered to.

5. Patient follow-up is mandatory, regardless of the therapeutic regimen prescribed.

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Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

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WILLIAM D. SMITH, MD
J. PATRICK EVANS, MD

The anterior surgical approach for bone grafting offers a safe and reliable method of obtaining union in cases where infection has not been present.

Tibial shaft fractures have a higher incidence of delayed union or non-union than do shaft fractures of any other long bones.^{4,11,14,15} A relationship between the severity of the injury that caused the fracture and the incidence of delayed union has been shown by numerous authors.^{3,6,9,11} Comminution, a fracture in the distal third of the shaft, infection, an open fracture and open reduction have been repeatedly incriminated as causal factors.^{5,9,11,14}

This study reports an additional series of delayed unions and non-unions of the tibial shaft. The purpose, in addition to reviewing causative factors, is to evaluate the results and complications of bone grafts performed from the anterior approach.

MATERIAL

A retrospective analysis of bone grafts from an anterior approach for delayed union or

non-union of tibial shaft fractures was performed. There were 32 such cases during a ten-year period from July 1962 through June 1972 at Bone and Joint Hospital, Oklahoma City, Oklahoma. The study included 27 males and 5 females with a mean age of 40 years. The length of follow-up was 5 to 60 months with a mean of 13.5 months. Table I presents in summary the patients reviewed.

In most cases the cause of fracture was a direct blow of considerable force. (Table II) There were 21 open and 11 closed injuries. Distal third and the junction of middle and distal third comprised the most common locations of fractures, occurring in 23 cases (72%). There were six located in the middle third and three in the upper third. Fourteen fractures were comminuted or segmental. It is noteworthy that one or more of the following factors existed in 30 non-unions (94%): comminution, an open fracture or a distal third location. In all of the unsatisfactory results or failures reported in this series, two or more of these factors were present.

The initial treatment included 10 cases using internal fixation and 22 using plaster or traction followed by plaster. Eight of the 21 open fractures had internal fixation while 2 of 11 closed fractures were internally fixed. The time between injury and bone graft ranged from four months to eight years. Excluding four cases, cases 9, 11, 23, 27, with exceptionally long histories of non-union, the mean time from injury to graft was 6.3 months.

TABLE I

Case	Age	Sex	Cause	Type and Location	Previous Treatment	Pre-Operative Infection or Skin Defect	Time to Graft (mos.)	Weight Bearing in cast (weeks)	Weight Bearing Unrestricted (mos.)	Length of Follow Up (mos.)	Type Graft	Results	Remarks
1	39	F	Auto—pedestrian	Open Comminuted Middle/3	Debridement and Irrigation Plate and Screws	None	5	2	3	6	Phemister type	Excellent	Iliac graft
2	50	M	Fall from a height	Open M/3	D and I Plaster	None	5	2	3	6	Phemister type	Excellent	Iliac graft
3	15	M	Motorcycle accident	Open Distal/3	D and I Plaster	None	5	4	3	8	Onlay plate and screws (compression)	Excellent	Iliac graft osteotomy of fibula
4	42	M	Fall from a height	Open Comminuted D/3	D and I Plaster	None	11	11	4	8	Sliding graft	Satisfactory	Local bone & simultaneous arthrodesis of wound healing
5	47	M	Kicked by horse	Closed D/3	Short leg cast	None	6	5	3	5	Phemister type	Excellent	Iliac graft
6	51	M	Fall from a height	Open Comminuted D/3	D and I Screw fixation	None	4	7	3	24	Inlay	Satisfactory	Iliac graft
7	62	M	Fell from a horse	Closed Comminuted D/3	Long leg cast	None	5	5	4	6	Onlay plate and screws	Excellent	Iliac graft
8	17	M	Motorcycle accident	Open Comminuted D/3	D and I Plaster	None	7	12	4	7	Phemister type	Excellent	Iliac graft delayed tibial wound healing
9	48	F	Automobile accident	Open D/3	Three previous bone grafts	None	96	8	3	7	Sliding graft and onlay screw fixation	Satisfactory	Iliac graft
10	17	M	Kicked by a cow	Closed M/3	Long leg splints	None	6	2	3	6	Phemister type	Satisfactory	Iliac graft fibular osteotomy tibial wound hematoma
11	19	M	Auto—pedestrian	Closed D/3	Previous sliding graft. Previous sequestrectomy	Yes	34	6	4	29	Sliding graft and onlay	Excellent	Iliac graft seroma—both wounds
12	48	M	Blunt trauma	Closed Comminuted M/3	Lottes nail fixation (1 week after injury)	None	10	2	3	18	Sliding graft and onlay	Satisfactory	Fibular osteotomy Iliac graft hematoma iliac wound
13	40	M	Automobile accident	Open D/3	D and I Plaster	None	6	6	6	18	Onlay plate and screws	Failure	Iliac graft upper GI bleed non-union
14	40	M	Automobile accident	Open D/3	D and I Plaster	None	16	8	4	7	Onlay compression plate and screws	Satisfactory	Iliac graft fibular osteotomy
15	57	M	Blunt trauma	Open Segmental M/3	D and I; Plaster Lottes nail fixation (3 mos. post injury)	None	8	6	3	5	Onlay screw fixation	Satisfactory	Iliac graft
16	33	M	Blunt trauma	Open Comminuted Upper/3	D and I Traction and Plaster	Yes (Skin graft required)	5	2	4	72	Onlay plate and screws	Failure	Iliac graft chronic osteomyelitis B-K amputation
17	50	M	Auto-pedestrian	Closed U/3	D and I Plaster	None	4	1	4	8	Sliding graft screw fixation	Satisfactory	Local bone
18	45	M	Kicked by horse	Open D/3	D and I Plaster	None	5	5	6	9	Sliding graft and onlay	Excellent	Iliac graft
19	45	M	Fall from a height	Open Comminuted D/3	Long leg cast	Yes (Skin graft required)	4	6	7	8	Sliding graft plate and screw fixation	Excellent	Local Bone mild reflex sympathetic dystrophy
20	27	M	Twisted leg	Closed D/3	Long leg cast	None	4	4	3	5	Inlay plate and screw fixation	Excellent	Iliac graft hematoma tibial wound

21	47	M	Slipped on ice	Closed Comminuted D/3	Long leg cast only	None	4	9	3	23	Onlay screw fixation	Excellent	Iliac graft
22	71	M	Fall from a height	Open Comminuted D/3	D and I; Traction 2 previous anterior bone grafts	None	6	6	4	5	Sliding graft	Satisfactory	Local bone fibular osteotomy
23	24	M	Motorcycle accident	Open Comminuted D/3	Blind Lottes nailing (2 weeks after injury)	Yes	96	2	4	35	Inlay and onlay	Excellent	Iliac graft fibular osteotomy
24	53	M	Blunt trauma	Closed D/3	D and I Plaster	None	5	8	5	12	Onlay plate and screw fixation	Satisfactory	Iliac graft removal Lottes
25	30	M	Oil field explosion	Open Comminuted D/3	Plate and screw fixation	Yes	6	8	9	31	Inlay plate and screw fixation	Unsatisfactory	Iliac graft chronic osteomyelitis
26	61	M	Automobile accident	Open D/3	Long leg cast	None	6	12	5	5	Phemister type	Excellent	Iliac graft
27	38	M	Horse fell on patient	Closed D/3	Pins and plaster	None	18	2	2	5	Onlay and Lottes nail fixation	Excellent	Iliac graft fibular osteotomy
28	40	F	Slipped and fell	Closed D/3	D and I Traction and Plaster	None	4	4	4	7	Onlay plate and screw fixation	Excellent	Iliac graft
29	43	M	Automobile accident	Open Comminuted U/3	D and I plate and screw fixation	None	8	1	2	6	Phemister type	Excellent	Iliac graft
30	19	F	Motorcycle accident	Open D/3	Long leg cast	Yes (Skin slough over fracture)	9	2	4	26	Sliding graft and onlay	Excellent	Iliac graft delayed tibial wound healing
31	25	M	Automobile accident	Open M/3	Long leg cast	None	7	1	2	6	Onlay Lottes nail fixation	Excellent	Iliac graft fibular osteotomy
32	33	F	Fell from a height	Open Comminuted D/3	D and I plate and screw fixation	Yes	4	10	5	6	Phemister type	Excellent	Iliac graft

TECHNIQUE

An anterior surgical approach was employed in all cases with the incision being made on either side of the crest of the tibia, avoiding any unhealthy-appearing soft tissue. In no case was active infection present at the time of surgery, although history of infection was present in seven cases. The type of graft (inlay, onlay or sliding) was individualized to the patient with internal fixation and osteotomy of the fibula being performed when indicated. Autogenous iliac bone was used in 28 cases. The remaining four were local sliding grafts without iliac supplementation.

The most common surgical method was iliac onlay (20 cases). Internal fixation was employed in 12 and the Phemister technique in eight cases. A sliding graft was done in nine cases, five of which were supplemented by iliac bone. Three of the sliding grafts added internal fixation. Finally, iliac inlay was used in three cases with one employing plate fixation. As a

group, 16 (50%) employed internal fixation with the graft. A fibular osteotomy was performed in eight patients (25%).

Full weight-bearing in cast was begun from 1 to 16 weeks post-grafting with a mean of 6.5 weeks. Full weight-bearing out of cast ranged

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J. Patrick Evans, MD, was graduated from the University of Oklahoma College of Medicine in 1963, where he is now Assistant Professor of Orthopaedic Surgery. Among his medical affiliations are the American Academy of Orthopaedic Surgeons, the American Academy of Cerebral Palsy, the American College of Surgeons, the Southern Medical Association and the Mid-Central States Orthopaedic Society.

TABLE II
Cause of Fracture

Motor vehicle accident	10
Blunt trauma	9
Fall from height	7
Automobile-pedestrian accident	3
Minimal trauma	3

from 6 weeks to 9 months with a mean of 3.9 months.

RESULTS

Results were graded according to the degree of normal function and activity obtained and were classified as follows:

Excellent—Full activity and weight-bearing without pain.

Satisfactory—Clinical and radiographic union but inability to gain unrestricted activity.

Unsatisfactory—Union but additional operative procedure required.

Failure—Persisting non-union or amputation.

There were 19 excellent and 10 satisfactory results at the end of the follow-up. There was one unsatisfactory result (Case 25) which despite union at 9 months post-operatively required two subsequent debridements for osteomyelitis. There were two failures. The first (Case 16) failure obtained union but underwent below the knee amputation for osteomyelitis 20 months post-operatively. The second (Case 13) failure had persistent non-union after plate fixation and iliac onlay. A repeat anterior graft was performed in Case 14 obtaining union and a satisfactory result. There were therefore three major complications: one non-union and two deep infections. (Table III) In the non-union there was no pre-

TABLE III
Complications

Major	
Non-Union	1
Deep Infection	2
Minor	
Hematoma	
Tibia	6
Ilium	2
Reflex Sympathetic Dystrophy	1
Upper GI Bleeding	1

or post-operative infection. In both of the deep infections, pre-operative infection had been present. There were five additional patients who had documented pre-operative infection. None of these developed post-operative infection and all obtained excellent results. Minor complications included hematoma or delayed healing in six tibial and two iliac wounds. None of these were infected and all cleared spontaneously. There was one case of mild reflex sympathetic dystrophy and one case of upper gastrointestinal bleeding.

DISCUSSION

The data presented again implicate the severity of injury, open fractures, comminution and a distal location as causative factors in delayed or non-union of tibial shaft fractures. A high degree of suspicion and an aggressive approach to this type of injury is suggested.

Boyd² has labeled bone-grafting operations "rewounding procedures," while pointing out that the procedure should be best suited for a given patient, "with the expectation that the bone will respond more favorably to the second wounding than it did to the first." While autogenous cancellous iliac bone graft has been generally accepted as the material of choice,^{1,12,13} the technique employed remains a matter of surgical judgment, depending on the type of non-union. The onlay, sliding and inlay grafts employed in this series are representative of the basic types. The Phemister modification¹⁰ of the onlay method is particularly useful when the bone fragments are in acceptable position and alignment. Internal fixation may be used when desirable with the onlay type graft. Sliding grafts offer stabilization using local bone and at times are helpful in obtaining arthrodesis of the neighboring joint. The inlay method used infrequently in this series requires a relatively large amount of cortical bone to obtain stability. This would seem of questionable merit with the current methods of fixation.

The surgical approach similarly is a matter of judgment. Posterior bone grafts have been effective in obtaining union in patients with infection or attenuated anterior skin.^{7,8} The efficiency of the anterior approach is unquestionable but the method should not be used in the presence of active infection and probably should not be employed when there is a past history of infection. In this series there were seven patients with a history of pre-operative

infection. Five obtained excellent results; however, two developed chronic osteomyelitis. One patient eventually required below the knee amputation. An excellent or satisfactory result was obtained in 24 of the 25 cases which had never been infected, even though 15 of these had been open fractures initially.

The series is comprised of 32 anterior tibial bone grafts, 21 of which were initially open fractures and seven of which had been previously infected to some degree. Union was obtained in 31 and an excellent or satisfactory result was achieved in all but three — the non-union and two patients with chronic osteomyelitis which were persistent problems after union was obtained.

SUMMARY

Delayed union and non-union of tibial shaft fractures are commonly associated with an open wound, comminution, and a distal location. The type of non-union should determine the technique of bone grafting. The anterior surgical approach offers a safe and reliable method of obtaining union when infection has not been present.

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Home Health Care

Citizens of Oklahoma who are homebound and under care of a physician are eligible to receive part-time intermittent skilled nursing, physical therapy, speech therapy and/or medical social services ordered by their physician if they reside within counties having a health department certified as a Home Health Agency. Requests for services are accepted from physician, patient, family, friends, or other agencies. A signed medical plan of treatment is required to provide the care needed. Services are available for all age groups (birth to death), all economic levels and to persons from any religious, racial, or ethnic background.

A physician wishing to learn more about services available locally for his patient should contact the local county health department public health nurse. She can assist him by determining the services his patient can receive locally.

Home health care services have been established to give part-time intermittent skilled nursing services ordered by the patient's physician at less cost, with the patient in



News From The Oklahoma State Department of Health

familiar surroundings, and with the family providing interim care. These services may include monitoring drugs and vital signs, giving injections, colostomy care, dressing changes, changing catheters; teaching patient and/or family to give injections, irrigate catheters, normal or special diets, and activities of daily living.

The goal of home health care services is to assist the patient in his recovery from an illness, to provide teaching necessary to maintain the patient at his highest level of wellness, and to provide skilled nursing care during a terminal illness.

If physical therapy, speech therapy or social worker services are necessary, the local health department will know about their local availability. Services are given regardless of the ability to pay. ☐

COMMUNICABLE DISEASES IN OKLAHOMA FOR OCTOBER, 1975

Disease	October 1975	October 1974	September 1975	Total To Date	
				1975	1974
Amebiasis	5	2	3	30	26
Brucellosis	—	2	—	3	9
Chickenpox	75	61	10	1084	933
Encephalitis, Infectious	9	8	7	55	51
Gonorrhea (Use Form ODH-228)	1239	975	1251	11068	9386
Hepatitis, A, B, Unspecified	52	62	87	706	850
Leptospirosis	—	—	—	—	2
Malaria	—	3	1	2	6
Meningococcal Infections	1	1	—	10	16
Meningitis, Aseptic	12	3	16	76	60
Mumps	20	9	10	236	397
Rabies in Animals	9	16	11	98	146
Rheumatic Fever	1	1	—	8	12
Rocky Mountain Spotted Fever	2	4	14	88	62
Rubella	3	3	—	89	62
Rubella, Congenital Syndrome	—	—	—	1	1
Rubeola	12	2	6	145	29
Salmonellosis	40	34	44	228	237
Shigellosis	12	12	31	284	151
Syphilis, Infectious (Use Form ODH-228)	15	12	6	80	121
Tetanus	—	—	—	—	2
Tuberculosis, New Active	19	43	17	261	270
Tularemia	—	4	—	9	18
Typhoid Fever	1	—	—	1	2
Whooping Cough	1	—	2	25	16

For Consultation Call: (405) 271-4060

Pay Television Planned for Medical Instruction

Pay television in the field of sports is far from being unusual, but to medicine it is a completely new concept, and Oklahoma physicians will be perhaps the first to benefit from this new idea.

The Internal Review Course, transmitted over Oklahoma's closed circuit Televised Instruction System, is perhaps the first opportunity for physicians to subscribe to a schedule of live television presentations for continuing education. The presentations are transmitted from the Basic Science Building at the University of Oklahoma College of Medicine every Thursday from 5:00 to 6:30 p.m. They can be viewed from any of more than 40 classrooms throughout the state.

Oklahoma's TIS network is designed and used primarily for academic instruction, serving colleges, universities and industries throughout the state. Already, four hospitals have installed viewing facilities and more are planning to do so as additional program offerings in the medical and allied health fields become available. The State Regents for Higher Education who operate the network have helped develop medical applications of the system, and the Learning Resources Center at the University of Oklahoma Health Sciences Center has provided local production resources.

A special feature of the TIS network is a "talk-back" capability which enables viewers in the various classrooms to ask questions which can be heard by the speaker. This two-way feature lends itself to an informal, classroom type of exchange. Continuing education credit for television participation is equal to that given physicians who travel to the lecture hall in Oklahoma City, and a portion of the \$35 per semester tuition fee goes to help defray the costs of television transmission. Since these programs cannot be viewed on one's home televi-



Doctor Dale Groom (left), Professor of Medicine and Coordinator of the Internal Medical Course, briefs lecturer Doctor Thomas Whitsett on television aspects of the first TV transmission of the sessions.

sion receiver, special arrangements must be made for admission to one of the network's classrooms, each of which has a local coordinator. When possible, handout materials provided by the speakers are distributed in advance through these coordinators who also handle enrollments in their localities.

This is the fourth year the Internal Medicine Review course has been offered by the OU College of Medicine. Its coordinator, Doctor Dale Groom, OU Professor of Medicine, arranged for the television transmission of the weekly lectures, available statewide for the first time this year. The current series of lectures emphasizes recent concepts and the broad field of internal medicine. The entire course is designed expressly as an organized preparation for certification or recertification.

The second semester of the program will run

news

from January 8th through May 27th, 1976. Course descriptions, speakers and available viewing sites are listed. The courses will again be offered every Thursday at 5:00 p.m.

Available Viewing Locations

Ada

East Central Oklahoma State University

Altus

Altus Air Force Base
Western Oklahoma State College

Ardmore

Ardmore Higher Education Center

Bartlesville

*Phillips Petroleum Company
Wesleyan College

Bethany

Bethany Nazarene College

Chickasha

University of Science and Arts of Oklahoma

Duncan

*Halliburton Services
Red River Area Vo-Tech

Edmond

Central State University

Enid

Phillips University

Granite

Oklahoma State Reformatory

Hodgens

Ouachita Vocational Training Center

Langston

Langston University

Lawton

Cameron University

Lexington

Lexington Treatment Facility

McAlester

McAlester State Prison
McAlester Vo-Tech

Midwest City

Oscar Rose Junior College
Tinker Air Force Base

Muskogee

Muskogee High School
Muskogee Veterans Administration Hospital

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University of Oklahoma

Oklahoma City

Kerr-McGee Corporation
Oklahoma Christian College
OSU Technical Institute
OU Health Sciences Center
Presbyterian Hospital
South Oklahoma City Junior College
Southwestern Junior College
Women's Correctional Facility

Ponca City

*Continental Oil Company
St. Joseph Medical Center

Poteau

Carl Albert Junior College
LeFlore County Hospital
Poteau Vo-Tech

Seminole

Seminole Junior College

Shawnee

Oklahoma Baptist University

Stillwater

Oklahoma State University

Stringtown

Vocational Training School

Tahlequah

Northeastern Oklahoma State University

Tonkawa

Northern Oklahoma College

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Oral Roberts University
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Tulsa Junior College
Tulsa Vo-Tech
University of Tulsa

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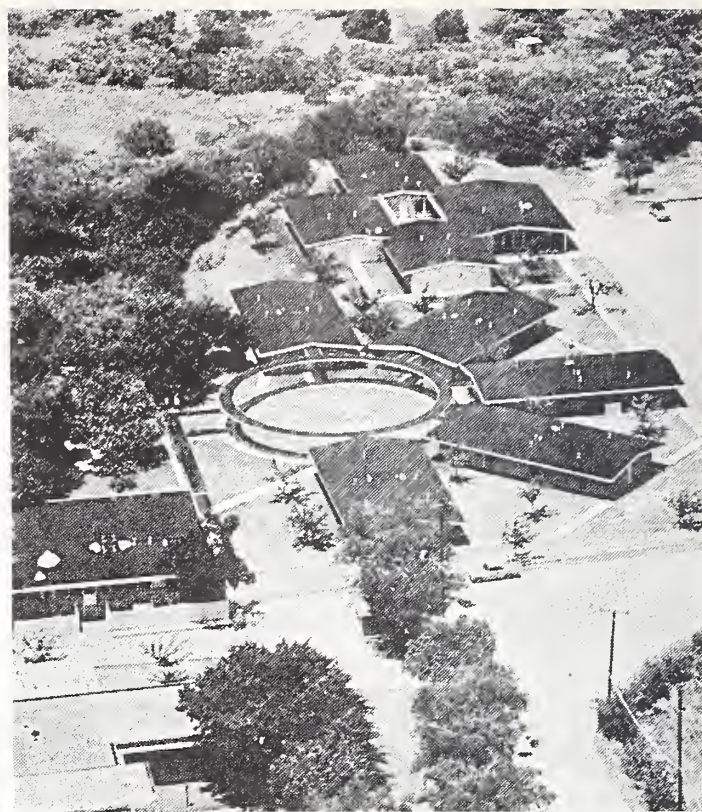
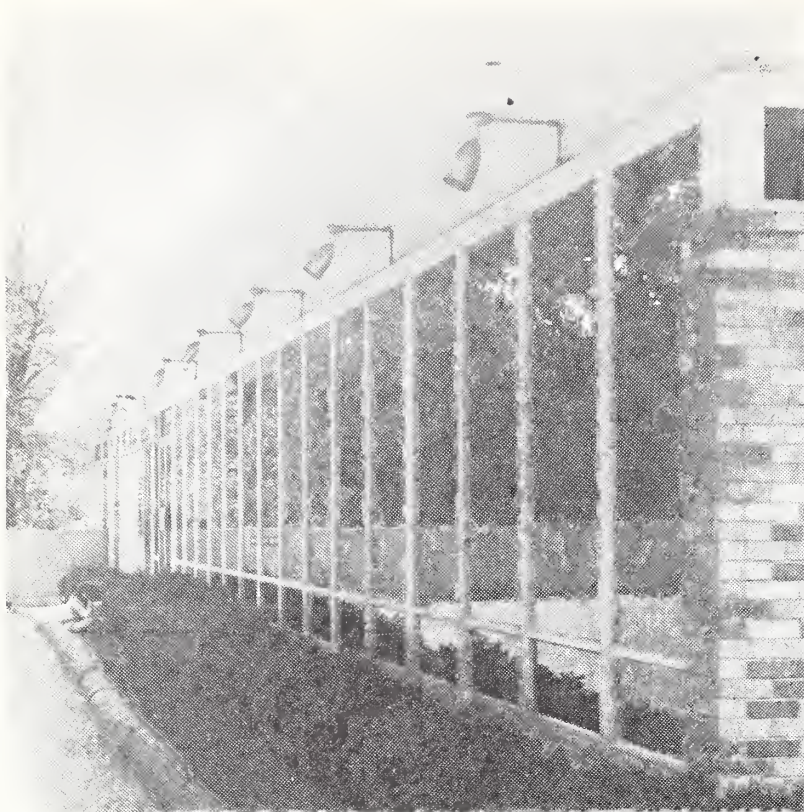
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INTERNAL MEDICINE REVIEW COURSE

1976

DATE	TITLE	SPEAKER
January 8th, 1976	ASCVD and Cardiomyopathies	Stephen D. Shappell, MD
January 15th, 1976	Pulmonary I—Recent Advances in Pulmonary Disease	C. Dowell Patterson, MD David Levin, MD
January 22nd, 1976	Pulmonary II—Use and Interpretation of Pulmonary Function Tests	Larry Ayers, MD Bernard E. Pennock, PhD
January 29th, 1976	Pulmonary III—Interpretation of Arterial Blood Gases—Respiratory Failure	Robert M. Rogers, MD Barry A. Gray, MD, PhD
February 5th, 1976	Diabetes, Hypoglycemia and Calcium	James Males, MD
February 12th, 1976	Renal I—Disturbances in Salt and Water Balance Deficits and Excess of Other Electrolytes	Solomon Papper, MD W. O. Smith, MD
February 19th, 1976	Renal II—Acid-Base Disturbances and Therapy	Chris Kaufman, MD Robert D. Lindeman, MD
February 26th, 1976	Renal III—Urinary Tract Infection. Stone Formation	Anthony Czerwinski, MD
March 4th, 1976	Renal IV—Acute and Chronic Renal Failure, Etiology and Management	J. A. Pederson, MD Anil K. Mandal, MD
March 11th, 1976	Infectious Disease I	John Mohr, MD
March 18th, 1976	Infectious Disease II	Hanna Saa'dah, MD
March 25th, 1976	Gastroenterology I	Gastroenterology Section
April 1st, 1976	Gastroenterology II	Gastroenterology Section
April 8th, 1976	Current Concepts of Hematology	Walter H. Whitcomb, MD
April 15th, 1976	Congenital Heart Disease in the Adult	Lotfy L. Basta, MD
April 22nd, 1976	Valvular Heart Disease	Eliot Schechter, MD
April 29th, 1976	Metabolic Disorders Presenting in the Adult	Sylvia Bottomley, MD
May 6th, 1976	Pituitary; Adrenal; Endocrine Hypertension	John R. Higgins, MD
May 13th, 1976	Thyroids and Gonads	Edward D. Frohlich, MD
May 20th, 1976	Hypertension	David C. Kem, MD
May 27th, 1976	Nuclear Medicine for the Internist	E. William Allen, MD



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Professional Liability Legislation OK'd

Five professional liability-oriented bills have been approved by the State's Interim Committee on Insurance. Three of the measures are supported by the OSMA and are a part of the OSMA legislative package.

Of the five bills receiving preliminary approval, two deal with perhaps the major problem in the current crisis — the lack of a definitive statute of limitations. Both bills would shorten the professional liability insurance "tail," — the time after an incident before a malpractice claim is filed. This time lag makes it impossible for insurance companies to determine their losses for many years after a particular policy year, and it helps drive insurance premiums higher each year.

The first bill, supported by the OSMA, would limit the filing period to one-year from the date of discovery or four years from the date of the incident, whichever is shorter. The other bill would place a strict five-year limitation from the date of the incident. The committee called for the two bills to be combined.

Another bill approved by the committee would create a 24-member medical panel with members selected from various professions. Cases involving suits of less than \$25,000 would be heard by the panel and resolved without jury trial. However, all cases regardless of size would be heard by the panel before the case could be taken to any court. Findings of the panel would be written and in cases where all parties agreed to the panel decision, no further action would take place. All parties would, however, have the right to pursue the claim through the usual judicial process in cases involving more than \$25,000. The OSMA Legislative Committee has not had the opportunity to review this bill, and has taken no action on it.

Two other bills proposed by the OSMA also received favorable committee action. One would permit the filing of counter-claims in non-meritorious malpractice cases, and the other would permit disclosure of collateral sources of recovery available to the plaintiff.

At the same time, "Do Not Pass" recommendations were given to two OSMA backed bills. One bill would require that any warranty or guaranty offered by a physician would have to be stated in writing, and the other would modify the application of the Res Ipsa Locquitor doctrine in malpractice suits.

All OSMA backed legislation, regardless of

the recommendation given by the interim committee, will be eligible for consideration by the Senate Committee on Insurance during the next session of the Legislature. □

Tulsa To Host Continuing Education Seminar

The American Medical Association's program of regional continuing education for physicians will be expanded next year to include a two-day session in Tulsa. The session, sponsored by the AMA's Council on Scientific Assembly, will be held January 17th and 18th at the Hilton Inn, 5000 East Skelly Drive.

State medical associations have placed more and more emphasis on continuing education in recent years. The new emphasis, coupled with mandatory requirements recently imposed on physicians in many states, have prompted the AMA to set up the weekend programs consisting of postgraduate courses. All courses will have syllabuses for home study, and qualify for Category I credit toward the AMA Physicians Recognition Award. The Tulsa program is a cooperative effort of the AMA, the University of Oklahoma College of Medicine, the Oklahoma State Medical Association, and the Tulsa County Medical Society.

The purpose of the program is to make continuing education readily available to physicians throughout the country. The regional programs are an outgrowth of similar programs presented at AMA Annual and Clinical Conventions. The six-hour courses are held on weekends for the physician's convenience.

Topics to be discussed at the January 17th and 18th sessions in Tulsa are: Child in the Emergency Room; Financial Management Colloquium; Basic Life Support-Cardiopulmonary Resuscitation; Recent Advances in Cardiac Management; Dermatology for Non-Dermatologists; Management of the Critically Injured Patient and Acid-Base, Fluid and Electrolyte.

An informative brochure giving specific dates, time and course fees has been provided to OSMA members. Further information is available from the Department of Continuing Education Seminars, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610. □

Medical-Dental Tennis Match Held



Two medical team players are pictured relaxing between matches. They are Lee Ison, MD, (left), and Farris Coggins, MD, (right).

The first Annual Invitational Indoor Medical-Dental Tennis Match was held on Sunday, November 9th, 1975, at The Courts in

Oklahoma City. Co-chairmen for the event were Stanley R. McCampbell, MD and J. Don Harris, DDS.

The medical team won eight singles and four doubles matches while the dental team won four singles and two doubles matches, giving the medical team a 12 to 6 victory.

Doctors participating on the MD Team were: Chester Beam, Farris Coggins, Lanny Anderson, Lee Ison, Stanley McCampbell, Daniel Lane, Harry Singleton, Raymond Hain, Ide Smith, John DeVore, Warren Felton and Philip Maguire. Dentists on the DDS Team were: Ken Hammond, Don Courts, Mike Baxt, Mike Fuaks, Joe Fallin, Don Harris, Lynn Holzberlein, Jerry Marshall, Butch Brimberry, Mike Keppenberger, Bill Lockard, and Hugh Burch.

Persons interested in participating in a National Dental Tennis Association should contact J. Don Harris, DDS, 3621 N.W. 63rd Street, Oklahoma City, 405 848-8838. Those interested in joining the American Medical Tennis Association may contact Farris Coggins, MD, National Vice-President, 5700 N.W. Grand Boulevard, Oklahoma City, 405 943-8521. □

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Hair Transplant Symposium To Convene In Hot Springs

The Third Annual Hair Transplant Symposium and Workshop will be held February 13th and 14th, 1976, at the Stough Dermatology and Cutaneous Surgery Clinic, P.A., Doctors Park, in Hot Springs, Arkansas. The meeting will be sponsored by the American Society for Dermatologic Surgery, the American Academy of Facial Plastic and Reconstructive Surgery and the American Association of Cosmetic Surgeons.

The program has been designed to offer an opportunity for the exchange of ideas among various disciplines and to present the latest advances in techniques on hair transplantation. Faculty members will include dermatologists, otolaryngologists, regional and general plastic surgeons.

For further information contact D. B. Stough, III, MD, Program Director, at the above address. □

Medical School Abandons Shortened Training Program

Are medical schools becoming disillusioned with the effort of the past decade to shorten the training period for physicians?

At least one medical school has — Rush Medical College in Chicago — and is changing its training period from the abbreviated three-year course to four years.

In a report in the *Journal of the American Medical Association*, William F. Hejna, MD, Rush dean, said:

"Many of the arguments advanced in favor of shortening the standard medical school curriculum to three years may no longer be valid, and such shortening may cause tensions among students and faculty. Further, this innovation does not materially address issues such as physician availability, quality and maldistribution."

Doctor Hejna pointed out that — in response to the need for more physicians — in the past ten years some 50 schools have instituted regular or optional three-year curricula. In the late 1960s, he said there was widespread attention to a national shortage of physicians.

As a result the number of schools has grown from 98 in 1968 to the present 114. Existing schools also increased enrollment, and there was a corresponding increase in first-year stu-

dents from 9,000 to 15,000. This will very soon cause a significant increase in the number of physicians practicing in the United States. There also has been a sharp upswing in migration of physicians from other countries to the US.

Thus, the doctor shortage is rapidly being met, and is no longer a valid reason to maintain a three-year medical course, Doctor Hejna said. He pointed out that the body of fundamental biomedical science which the medical student must absorb continues to increase, and that the behavioral sciences have taken on new importance and time in medical schools.

At Rush, 55 per cent of the students favored extending their training to four years. The shorter course meant going to school straight through the summer, with no break for three full years in the demanding study schedule. □

DEATHS

CLARENCE O. EPLEY, MD
1882-1975

Clarence O. Epley, MD, 92, Oklahoma City general practitioner, died November 25th, 1975. Born near Shell Rock, Iowa, Doctor Epley was graduated from the University of Illinois College of Medicine in 1910 and moved to Oklahoma City in 1930. He retired from active practice in 1961. Doctor Epley was a member of the American Academy of General Practice and a Life Member of the Oklahoma State Medical Association.

DAVID CARSON, MD
1924-1975

A 51-year-old Fairland physician, David Carson, MD, died October 13th, 1975. A native of Tonkawa, Oklahoma, Doctor Carson was graduated from Tulane University School of Medicine, New Orleans, in 1948. Following two years of work with the US Public Health Service, he moved to Miami, Oklahoma. He had practiced in Fairland for over 25 years. Doctor Carson had served as President of the Craig, Ottawa, Delaware Medical Society and as a Delegate to the OSMA House of Delegates. □

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Two Tulsa Physicians Honored

Two Tulsa physicians, Hays R. Yandell, MD, (center) and Donald L. Mishler, MD, (right), are shown as they receive certificates of Life Membership in Oklahoma State Medical Association. Making the presentation is Harold W. Calhoon, MD, of Tulsa (left), member of the OSMA Board of Trustees. The plaques were presented in ceremonies at the November 10th meeting of the Tulsa County Medical Society.

Doctor Yandell retired in 1973 as senior surgeon of the Glass-Nelson Clinic of Tulsa. A graduate of Harvard Medical School, he practiced for several years at Ponca City before coming to Tulsa in 1941. Doctor Yandell is widely known for his leadership in hospital and surgical circles.

Doctor Mishler is in the active practice of otolaryngology and plastic surgery of the face. A graduate of State University of Iowa Medical School, he practiced briefly in Nashville, Tennessee, before entering practice in Tulsa in 1934. □

Critical Care Medicine Course Slated For February

The University of Oklahoma College of Medicine will present the Third Annual Critical Care Medicine Course February 29th to March 5th, 1976. Selected critical care medicine topics in areas having an increase in knowledge or an improvement in skills will be presented by university and guest faculty.

Registration and the \$300 tuition fee should be forwarded to the course director, Robert M. Rogers, MD, Critical Care Medicine Course, Department of Medicine, University of Oklahoma Health Sciences Center, P.O. Box 26901,

Oklahoma City, Oklahoma 73190. Tuition includes coffee and rolls, five luncheon symposia, afternoon and evening workshops, a complete course syllabus, and six days in the Learning Resources Center, where over 100 self-instructional programs are available including lectures from previous critical care courses.

Acceptance is on a first-come, first served basis and application should be received by February 14th, 1976.

This course has received the endorsement of the American Thoracic Society and participants will receive up to 42.5 hours credit in Category 1 for the Physician's Recognition Award of the American Medical Association. □

Program Promotes Student Interest In Primary Health Care

Last summer Dan Donnell was one of 14 University of Oklahoma medical students who received local health care experience through MECO — Medical Education Community Orientation. Now he says he will return to Idabel where he participated in MECO, to set up his practice when he graduates.

The MECO program was developed in 1969 under a grant from the Sears Foundation, but last summer was its first operational year in Oklahoma. In all, 14 medical students took part in the first program, but Donnell, who is the project director in Oklahoma, says he hopes to double the number of participants this year.

MECO is a nationally coordinated network of educational programs for pre-clinical medical students designed to introduce the student to primary medical care early in his academic career. The students who participated last summer spent eight weeks working for a cooperating hospital in the state. Donnell worked at the hospital in Idabel, where he now plans to practice.

Donnell, however, was not the only student impressed by the prospects of family practice in Oklahoma's small and medium-sized communities. Eight other students said they would like to return to the same community to practice, and two more said they would be interested in similar communities. Nationwide, participating students almost unanimously endorse the program. Seventy-five per cent say they would like to return to the same community to practice.

During the eight summer weeks, the student.

(Continued on Page 484)

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works with the hospital and his preceptor-physician in providing health care. The student sees patients with his sponsor physician, and he gets out into the community through public health and welfare department contact. In short, MECO offers local involvement and gives participants a chance to learn health care at the community level. Most students say the program, which is designed for first and second-year medical students, helps them plan their career goals and better plan their medical education.

The small cost to participating hospitals and physicians is probably more than offset by the increased interest in general practice which MECO seems to generate. During the student's stay, he is normally paid a stipend of approximately \$85 per week, plus room and board. Usually, the medical staff and the hospital association of the sponsoring community pay the stipend, and students are accommodated in hospital owned facilities or in the homes of physicians in the area. Meals are often provided in the hospital cafeteria.

The perceptors primary cost is his own time, but many report that having a student with them slows them down much less than they expected. Additionally, the American Academy of Family Practice grants 30 hours of continuing education credit for any member participating in the program, and the American Medical Association's Council on Medical Education recommends 18 hours of credit to any physician, regardless of specialty, for three summers of participation.

Donnell says applications for next summer's program will be mailed to eligible hospitals around the first of the year. The deadline for returning the application is February 15th, 1976. Anyone wanting additional information about MECO is invited to contact Dan Donnell, Oklahoma Council for Health Careers, 715 N.E. 14th, Oklahoma City, Oklahoma 73104. □

Lupus Association to Award Grants

The Oklahoma Lupus Association, Inc., will be awarding a grant for research into the cause and cure of lupus erythematosus (an incurable disease afflicting 500,000 persons in the United States). The 1975 grant, consisting of ap-

proximately \$2,400, was raised through memorial contributions, donations, and fund-raising activities held by lupus patients, their friends and relatives. Additional funds for research can be contributed to the Lupus Research Fund.

Requests for the grant should be submitted to the Oklahoma Lupus Association office, 3848 N. W. 31st Street, by January 1st, 1976. The grant is to be used for lupus research and is not to be used for travel or salaries. All requests should include a complete description of the specific research activities already engaged in, as well as contemplated, and should give information on how the grant will be utilized if awarded. After all applications have been evaluated by the medical advisors, and they have made their recommendation, the Lupus Association will select a recipient and the grant will be awarded in May, 1976.

The Oklahoma Lupus Association has been supporting lupus research, providing educational information concerning the disease, and giving moral support to patients and their families since August of 1973. □

Three Legislators Urge Caution

Three state legislators met recently with OSMA's Professional Liability Study Commission to give advice on malpractice insurance legislation due to be considered during the next session of the Legislature. The consensus: *OSMA should move deliberately, learning from the mistakes made in other states.*

Representative Kent Frates (R-Oklahoma City), Representative David Craighead (D-Midwest City), and Senator James Howell (D-Midwest City) all expressed concern over what may be the initial stages of an insurance crisis in Oklahoma. Each of the legislators said he was anxious to prevent the same kind of crisis many states are now experiencing.

Representative Frates said the Oklahoma Legislature should be receptive to OSMA's ideas since it is consumer oriented and the issue of professional liability insurance boils down to a consumer problem. He recommended a direct but deliberate approach which attacks the total problem, not just the problem as it relates to physicians.

In a final word, he urged the OSMA and other groups to approach the question as a "class of people who have a special problem, not as a special class of people."

Senator Howell strongly urged the OSMA to

carefully inspect its legislative package to make sure all proposed legislation would aid physicians not only now, but also in the future. Rather than pass a bad law, he said, it would be better to pass no law at all.

Representative Craighead said he was concerned about liability insurance becoming unavailable in Oklahoma. He suggested that the Oklahoma Legislature should look at legislation proposed in other states to see if it is applicable to the situation here. Representative Craighead cited a bill being considered in Indiana as a particular piece of legislation which could possibly be useful in Oklahoma.

As the meeting progressed, the professional liability (malpractice) insurance crisis became more and more evident. Rod Frates, OSMA insurance counselor, explained that in 1976, insurance rates will increase substantially.

According to Frates, physicians in Oklahoma will pay 50 per cent more next year for the basic \$100,000 policy and nearly 200 per cent more for the umbrella policy. He also warned that physicians in many states face even larger increases. One of the main reasons, he said, is the lack of a competitive insurance market. The national crisis, said Frates, has forced many companies out of the market and

today only six companies still write the basic policy.

A similar, but even more critical account was given by Ben White, associate executive director of the Oklahoma Hospital Association. He said the St. Paul Fire and Marine Insurance Company which writes a majority of the insurance for hospitals is in the process of pulling out of the market in Oklahoma, leaving 59 hospitals without insurance. He said even those hospitals which are able to renew their premiums with other companies are facing rate hikes of up to 1,000 per cent.

As a result of this meeting, several similar meetings, and a conference with Governor David Boren, the OSMA has pushed forward with a package of bills designed to at least partially remedy the insurance crisis. The bills deal with specific areas of the professional liability insurance crisis, and if passed, should help not only physicians, but also all other professionals affected directly by the problem.

To date, three of the five OSMA backed bills have received a favorable recommendation from the Interim Legislative Counsel's Committee on Insurance. The entire OSMA package will be reviewed during the next session of the Legislature. □

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Legislative Battle Appears Likely

The final, most important decision affecting patients and physicians in Oklahoma could very well come during the next four or five months. The nature of the decision and how well informed the makers are may help mold the standards of health care for years to come. The issue of course will be professional liability legislation and the arena will be the State Capitol — or more specifically, the Oklahoma Legislature.

Throughout the nation, legislators, physicians and attorneys are all readying themselves for a campaign which will ultimately decide the future course of the medical profession. If meaningful decisions are successfully blocked by special interest groups, the professional liability situation will likely continue its steady, methodical deterioration. If bad laws are passed, whether well-intended or not, the situation could very easily collapse suddenly, sending thousands of physicians into other professions and leaving large regions of the country without medical care. How well we inform both our representatives in Oklahoma City and our public throughout the state could very well determine what course this important legislation takes.

For years patients and physicians in this state have been blessed with perhaps the most stable insurance program in the nation. As a result, health care costs have remained reasonable and the profession has grown. It is pure folly, however, to believe that Oklahoma can continue to prosper while the rest of the country struggles. We have already been caught up in the national crisis and the situation, if left unattended, will only worsen.

In just one year, insurance rates for Oklahoma physicians have increased by frightening percentages. Although professional liability

insurance rates are still uncommonly low in this state, the hand writing is on the wall. Insurance rates will continue to escalate and the unavailability problem will steadily grow until effective steps are taken to counteract the trend and attack the basis of the problem.

Throughout the past summer and fall, the OSMA staff has carefully monitored state and national legislation which would deal with the problem. The OSMA's Council on Insurance and the Professional Liability Study Commission, have helped draft a package of bills which, if passed next session, should protect both the Oklahoma physician and his patient against unreasonable increases in health care costs and a total collapse of the insurance market which has already occurred in several other states. What ultimately happens to this package depends largely upon the kind of support which we can generate for the issue and how much input the association and its members have in the final decision making.

Doctors, it's no exaggeration to say that the next few months could determine your future, your family's and your profession's. The OSMA staff and its leadership have spent many hours developing our legislative package and explaining it to leaders of the House and Senate. Now, it is important that we all get behind it and push for its passage. To under estimate the importance of this issue would be a terrible mistake; to under estimate the power of our adversaries would be even worse.

A grass-roots campaign would be the most effective way to fight the problem, but for it to be successful, widespread support is essential. Please help by telling your patients and your representatives how important this issue is to us *all*. If we wait much longer, it may just be too late. *Richard Hess, Director of Communications, OSMA* □

At the AMA convention in Atlantic City, a new project to be sponsored by the AMA Auxiliary was introduced, discussed and thoroughly studied by the state presidents and presidents-elect.



This new and exciting idea is "The Project Bank." It will take a lot of work and cooperation to get it going and running smoothly but it can be a great service and just what the average auxiliary needs to stimulate its membership and their need in behalf of the well being of people in their communities.

The concept was brought about to provide better communication at all levels of the auxiliary, to enable national to have a tangible service to offer state auxiliaries, and to provide a workable system through which the auxiliary can meet community needs through emphasis on program development at the state and county level. In short — this means — "calling upon the women to look at the needs in their communities and doing something about it."

The bank should prove valuable also to the physician's spouse who is a member-at-large of the auxiliary. These individuals are often the lone representative of the auxiliary in their community and must always work with other groups to solve the health related problems in their community.

The Project Bank consists of catalogued information kept at national headquarters. It is information from which state and county auxiliaries can obtain materials on community service projects which have been successfully developed and implemented by other auxiliaries across the country, plus resource and program information from other health-related organizations including the government.

A national coordinator and eight area councilors will work as a committee to research and develop projects, with assistance from national headquarters on paperwork. The area councilors, two in each auxiliary region will be assigned specific states in which to work. They will work through state project chairmen, consulting with them on how best they can be used.

The job of these nine auxiliary members will be to encourage auxiliaries to identify com-

munity needs by suggesting ways in which it can be done, providing information to meet that need from the project bank and then helping to implement the program in any way the auxiliary wishes. As information is sent to these area councilors on projects being implemented in the various states, they will send the information to national where it will be put in a standardized form, catalogued and filed.

Every attempt will be made to match materials to the size of the county, volunteers and funds available, etc.

Each state auxiliary has received two or three project bank catalogs. Each county auxiliary is urged to examine these catalogs. If they find their individual projects are not covered, they are requested to write them up and send them in to their state project chairman.

Loretta Renfrow and I are co-chairmen on the project at the state level and we will strive to do our best to serve the needs of our auxiliaries.

"A World of Knowledge" awaits the auxiliaries if they will use this Project Bank.

Marie Haddock (Mrs. James L.), President-Elect, Woman's Auxiliary to the OSMA

Please send your contributions to

AMA — ERF

to

AMA-ERF
535 North Dearborn Street
Chicago, Illinois 60610

or

Mrs. Tony Puckett
12009 Brookhollow Road
Oklahoma City, Oklahoma 73120

Guess who's first and last in the latest leadership poll. You're right, the medical profession came in first and Congress was last. Of those polled, 69 per cent expressed confidence in medicine's leadership and Congress ranked last with a 34 per cent confidence rating. Those questioned in the Harris survey were asked whether the leaders in each group "really know what most people want" or are "mostly out of touch with their constituents." In a separate Roper poll, eight out of ten respondents said they were either "very" or "fairly" satisfied with the quality and availability of their health care, but, at the same time, a majority said the cost of health care was "unreasonable." According to the poll, 70 per cent believe that health care costs have been rising faster than the cost of living, with the chief factors being hospital costs, physicians' fees and malpractice suits in that order. The Roper poll also found that four out of ten people believe "almost all" charges of malpractice against physicians are justified, while three of ten thought "very few" charges of malpractice were warranted. The same poll showed that 50 per cent of the public favor private health insurance and 41 per cent want national health insurance.

A new, IRS qualified retirement program for OSMA members will begin accepting enrollments soon after the first of the year. A brochure explaining the program will be sent to both incorporated and unincorporated physicians in late December. Self-employed physicians will be able to enroll in a Keogh-type program and set aside up to \$7,500 annually without paying current income tax on that portion of their earnings. Incorporated doctors will be offered an option to enroll in either a profit-sharing or a corporate-type tax-sheltered program to be sponsored by the OSMA. Physicians

in this group may set aside a larger percentage of their annual earnings. The First National Bank and Trust Co. in Oklahoma City will serve as the Trustee and the Massachusetts Mutual Life Insurance Co. will underwrite the insurance portion of the retirement packages.

A plan to reduce the number of surgeons going into practice each year from 2,600 to 2,000 is being considered by the American College of Surgeons. According to an account in *Health News Report*, the plan was introduced at the annual ACS meeting and is based on the "Study on Surgical Services for the United States" released earlier in the year. Under the plan, the percentage of physicians specializing in surgery would be reduced from the present 21 per cent to 18 per cent. The reduction would be accomplished by withdrawing ACS approval from certain surgical training programs.

Patients are feeling the effects of California's professional liability crisis through higher medical bills, says a report by the California Medical Association. The survey shows that physicians' fees rose 6.7 per cent in the state during the first six months of 1975 compared with a nationwide fee increase of 5.9 per cent. In Northern California, where premiums jumped as much as 375 per cent, fees rose an average of 12 per cent.

The Alabama Medical Liability Act was signed into law by Governor George C. Wallace recently making Alabama the 35th state to enact medical liability legislation this year. Tort reforms contained in the bill include elimination of the ad damnum clause in lawsuits, a change in the statute of limitations, and a concise definition of malpractice coupled with a requirement that warranties for cure must be stated in writing. The bill also allows periodic payment of awards and permits voluntary, binding arbitration of claims. Under the law, insurance carriers will be required to report annually on their medical liability claims experience to the State Insurance Commissioner. Similar legislation is now pending before the Oklahoma Legislature. □





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